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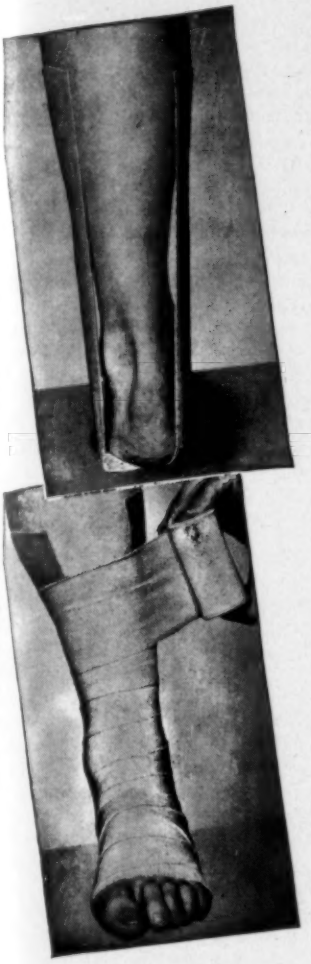
TRADE MARK



In order to guard the external lateral ligament against repeated strains, the foot should be prevented from inversion, and any action that tends to twist the sole of the foot towards the midline should be avoided. This is accomplished by strapping the ankle in eversion while at the same time allowing the normal range of plantar and dorsiflexion. Firstly, a wedge of adhesive felt, about 2½ inches in length and 1 inch in width, is placed along the outer border of the heel, so that when weight is taken on the foot it is thrown into eversion.

Secondly, a strip of 2½ inch Elastoplast Extension plaster, about 2 feet in length, is used to strap the foot in eversion. One end of this is applied to the inner aspect of the calf and, while this is held in position, the remainder is run round under the heel so that when the other end is pulled up on the outer side of the calf, the foot is forced into eversion (Fig. 1). It will be noticed at this point that there is a space on each side where the plaster does not touch the lower end of the leg or ankle. Elastoplast Extension plaster has the advantage that while it is elastic in its width, and so follows easily the contours of the leg, it is firm in its length and gives continuous support.

The strapping is completed by bandaging the leg over the extension plaster with ordinary Elastoplast from at least 6 inches above the ankle to the metatarsal heads (Fig. 2). This keeps the whole dressing in place and eliminates the space between the extension plaster and the ankle.

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Between Ourselves

As noted in our story of the day-by-day activities at the C.N.A. convention one highlight was the intensely interesting report given by **Dr. A. R. Lord** on his findings in connection with his ***survey of the Metropolitan School of Nursing.*** There was none of the usual trickling out of listeners as so often occurs, despite the nearly 90 minutes the exposition took. Requests have been pouring into our National Office for printed copies of the report. These will be available to interested nurses from *National Office, C.N.A., Suite 401, 1411 Crescent Street, Montreal 25, Que.* Until the printing is completed no figure has been set relative to the cost per copy to individual purchasers.

In the meantime, a concise 1,000-word summary has been prepared by Dr. Lord. It is presented here as a foretaste of what will be found in the report proper. The latter will not be published in the *Journal.*

* * *

Exchange of positions is so common among members of the teaching profession, one wonders why so few nurses availed themselves of the opportunity similarly. Requests to the special C.N.A. committee for ***assistance in arranging for such exchanges*** were so few and far between that the committee was discontinued this year by the C.N.A. Executive. Henceforth, any such requests are to be made directly to our National Office.

Perhaps if nurses had realized what marvellous opportunities are afforded for becoming familiar with the culture and customs in another country, more requests for exchange would have been forthcoming. Read **Roxina Brandon's** account of her experiences in Coventry, England, without fail.

* * *

We thought you would be interested in **Velma Johnston's** comments on her paper—***The Head Nurse***—which appears on the Institutional Nursing Page:

"On re-reading this assignment two years after it was written, it amuses and amazes me that I had the nerve and the audacity to attempt to outline the position of a head nurse without having had any experience myself. Now, after being closely associated with head nurses, as clinical instructor on a ward, I can see that all I said was true but it is not as easy as it sounds and there is much more involved in this position.

"The head nurse, to me, is the 'King Pin' of any institution, for on her shoulders rests the responsibility of the nursing care the patients receive, the administration of the ward, personnel relations of her staff, and all of its other activities. It is her ability and her personality that set the tempo of the ward and the success or failure of its activities depends on her. It is a difficult position to fill and now I feel even more strongly that added preparation and education are essential if she is to realize all her job entails and is willing to cooperate in a clinical program of teaching. The position is, indeed, a challenge but, as stated before, it cannot be filled by *any* graduate but rather by one with a strong, mature personality and a good sense of humor."

The malignant neoplasms (very largely cancers) bring death to more males than females. The sex difference in mortality varies widely, however, with age. Actually, the excess mortality among the males is observed only at the ages under 25 years and past 55 years. At ages 25-34, the death rate from the malignant neoplasms was 14 per cent lower for men than for women; at 35-44 years, the rate was 31 per cent lower. Beyond this point the ratio of male to female mortality increases rapidly with each advance in age. At 45-54 years the death rate is about the same in each sex and in the next two decades of life the rate among the men is nearly 1½ times that for the women.

With few exceptions, malignant growths of the various parts of the body show a higher mortality among males than females, not only in the aggregate but at the individual age groups as well. Malignancies of the respiratory system record the greatest excess male mortality, with a death rate 7⅔ that for the females at the ages under 75; at 45-64 years it is from 9 to 10 times as high. The sex difference has been widening for more than a decade as the death rate from respiratory cancer has been increasing much more rapidly among males than among females.

— *M.L.I.C. Statistical Bulletin*

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Edited by **PROFESSOR F. N. HUGHES**

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VEBEX-FORT

Manufacturer—Mowatt & Moore Ltd., Montreal, Que.

Description—Each tablet contains: Thiamine mononitrate 12 mg., riboflavin 7 mg., niacinamide 75 mg., pyridoxine 0.5 mg., calcium d-pantothenate 5 mg., ascorbic acid 30 mg., liver and yeast concentrate 260 mg.

Indications—Treatment of vitamin B and C deficiency states.

Administration—One tablet three times a day or as prescribed.

BENEMID PROBENICID

Manufacturer—Sharp & Dohme (Canada) Ltd., Toronto, Ont.

Description—Benemid Probenecid [p-(di-n-propylsulfamyl) benzoic acid] 0.5 gm. in each tablet.

Indications—Designed to effect a favorable balance between production and excretion of uric acid. Helps to guard against the development of gouty arthritis and to diminish the severity and frequency of acute attacks of gout. There is also evidence that in conjunction with proper diet, Benemid will aid in reducing established tophi.

Administration—In the treatment of chronic gouty arthritis and the interval treatment of gout, it is recommended that one Benemid tablet (0.5 gm.) be administered daily for one week, followed by two tablets (1 gm.) daily in divided doses. In some cases it may be desirable to increase the daily dosage to four tablets (2 gm.) to secure optimal uricosuric effects.

CHLOROMYCETIN PALMITATE PEDIATRIC

Manufacturer—Parke, Davis & Company Ltd., Walkerville, Ont.

Description—A pleasant, custard-flavored suspension containing chloromycetin palmitate, a tasteless derivative of chloromycetin (chloramphenicol, P.D. & Co.) which, in the gastrointestinal tract, promptly hydrolyzes to release free chloromycetin. Each teaspoonful (4 cc.) contains the equivalent of 125 mg. of chloromycetin.

Indications—Provides a pleasant method of administering easily-adjusted oral dosages of chloromycetin to children. It is a stable suspension and requires no refrigeration.

RIMIFON

Manufacturer—Hoffmann-La Roche Limited, Montreal, Que.

Description—A new, potent antituberculous agent, the hydrazide of isonicotinic acid (isoniacin).

Indications—Clinical trials have shown its effectiveness in most forms of pulmonary and extra-pulmonary tuberculosis. Numerous additional investigations are under way to obtain further information regarding this drug.

Administration—Dosage is calculated on the basis of 2 to 4 mg. per kg. of body weight per day. The tablets are taken in three or four divided doses immediately after meals.

How Supplied—At present, Rimifon is available for experimental use only to hospitals and sanatoria.

TROPHITE

Manufacturer—Smith, Kline & French Inter-American Corporation, Montreal, Que.

Description—Each teaspoonful (5 cc.) of elixir contains: Vitamin B-12—25 mcg., Vitamin B-1—10 mg.

Indications—As an adjunct in treating the chronically ill or undernourished child, to improve the appetite and growth of the child who does not eat adequately, and as a nutritional supplement in chronic diarrhea and celiac disease.

Administration—One teaspoonful daily or as prescribed. If desired, may be mixed with water, milk, fruit or vegetable juice.

SARAKA TABLETS

Manufacturer—Schering Corporation Limited, Montreal, Que.

Description—Each tablet contains Bassorin and Cortex Frangula combined with sodium carboxymethylcellulose.

Indications—For use in habitual and occasional constipation where a gentle non-purging action is desired.

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DI-IODO-TYROSINE

Manufacturer—Organon Canada Ltd., Montreal, Que.

Description—Each tablet contains 0.1 gm. 3, 5-diiodo-4-hydroxyphenylalanine, an easily assimilated organic iodine compound for oral use.

Indications—For pre-operative preparation for thyroidectomy, for prevention and treatment of simple colloid goitre.

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Manufacturer—Geigy Pharmaceuticals, New York.

Description—Contains N-ethyl-o-crotonotoluied (crotamiton) an antipruritic and scabicide 10% in a vanishing cream base.

Indications—For prompt, prolonged relief of itching.

Administration—Apply by massage as often as necessary, usually every 6 to 8 hours. Contraindicated in severe, acute dermatitis, particularly with vesiculation and oozing.

HYDROCORTONE ACETATE

Manufacturer—Merck & Co. Limited, Montreal, Que.

Description—Saline suspension containing in each cc. 25 mg. of 17-hydroxycorticosterone 21-acetate (hydroxycortisone acetate), also designated as Compound F.

Indications—For injection into the articular cavity of rheumatoid or osteoarthritic joints. Should not be used in any specific arthritis—e.g., gonococcal or tuberculous.

Administration—Intra-articularly in doses and following directions recommended.

MEDOPAQUE-H

Manufacturer—Bell-Craig Limited, Toronto, Ont.

Description—A non-toxic, sterile, viscous (250 centistokes), aqueous solution containing 45% sodium orthoiodohippurate and 1.83% sodium carboxy-methylcellulose with added stabilizer and preservatives. Iodine content is 15.8% w/v.

Indications—An aqueous contrast medium for hysterosalpinography for the detection of tubal patency, sub-mucous fibroids, polyps, hyperplasia and malignancy of uterine cavity and cervical canal. Also in cholangiography for the radiographic visualization of the biliary duct system.

Contraindications—Not to be used intravenously intraspinally, in cavities of the C.N.S., or for retrograde pyelography. Intrauterine injection is contraindicated in pelvic inflammatory diseases, active bleeding from the genital canal, pregnancy, recent curettage and sensitivity to iodine. Also contraindicated in cholangiography in the presence of acute biliary tract inflammation.

PLEXONAL

Manufacturer—Sandoz Pharmaceuticals Ltd., Montreal, Que.

Description—Each sugar-coated tablet contains sodium barbital 45 mg., sodium phenobarbital 15 mg., sodium sandoptal 25 mg., dihydroergotamine methanesulfonate 0.16 mg., scopolamine hydrochloride 0.08 mg.

Indications—Hypnotic and day-time sedative.

Administration—As a hypnotic—1 to 3 tablets ½ hour before retiring. As a day-time sedative—1 or 2 tablets 2 or 3 times daily. Maximum daily dosage—8 tablets.

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Manufacturer—Parke, Davis & Company Ltd., Walkerville, Ont.

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The
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PUBLISHED BY THE CANADIAN NURSES' ASSOCIATION

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MONTREAL, SEPTEMBER, 1952

The Three R's

SEPTEMBER and all over Canada thousands of tads will be starting along the road that leads to maturity and education. Some will travel far — to advanced degrees in famous universities. Some will poke along and leave school as soon as the legal age-limit will permit. Some, through no fault of their own, will not journey as far along the educational lanes as they would wish. Some, prodded by ambitious parents, will squeak through year after year. Some of these thousands will be the new preliminary students entering our schools of nursing a dozen years hence. How well prepared will they be to enter upon their careers in nursing?

A couple of pertinent observations come to mind in considering a suitable answer to that question. Since these points have some bearing on our unending quest for candidates for our schools of nursing, let us ponder upon them briefly.

Perhaps the first consideration should be that no two of these thousands of students who start public school are exactly alike. Because they should be treated as individuals — they cannot be pigeonholed or poured into molds. Parents want their children to be something more than just a part of any classroom pattern. They expect the school to assume definite responsibilities in meeting the individual as well as the group needs of the children.

This effort on the part of schools to try to understand students as individuals, as well as a part of a school community, has led them to develop guidance programs. Over the years, these programs have become a significant part of modern education.

Actually, the great majority of schools do provide some guidance service without necessarily calling it that. Without being consciously aware of it, every good teacher, from the children's first days at school, tries to take care of the individual needs of her pupils in addition to providing mass instruction. Nurses who visit the schools have an important role to fill in supplementing the teachers' interest in, concern for, and knowledge of the children.

The nurses can accomplish a great deal more by their own interest in the

young girls. Long before Grade VIII is reached, when so many of the youngsters leave school, the nurses can, by their example, their enthusiasm, and by planned conversations with suitable girls, plant a seed of interest in nursing that will bear fruit many years hence.

An excellent plan that may be worked out in any elementary, junior high, senior high, or ungraded school is open to every one doing school nursing. This consists of the selection of a group of promising girls who can be trained by the nurse to assist her when she is in the school, who can be responsible for the care of the medical supply cupboard, and who can be entrusted to do simple dressings in the nurse's absence. Out of one such group of eight public school girls who became efficient assistants, six eventually graduated from schools of nursing.

Another quite different aspect of the problems of present-day education is to be found in the apparent inability of many candidates to schools of nursing to spell, write legibly, or do the simple arithmetic that is essential in computing quantities in drugs and solutions. Grammar seems to be another hurdle many high school graduates cannot jump. A recent letter from an erstwhile subscriber, a graduate nurse, reads: "I am married now so don't want the magazine no more. If I had of wanted it I would of sent you money."

We are forced to conclude that the educational systems in every province, while they may realize their objective of keeping children interested, do not always provide a sufficient grounding in the three R's. In consequence, precious hours have to be wasted, during the preliminary period, teaching the students the fundamentals of fractions, how to print properly, sometimes even how to spell. Ironically, schools of nursing have found that it is not that the girls are incapable of doing the required sums, of writing or printing a tidy script, but that *they had never been taught how*!

It is highly improbable that this unsatisfactory state of basic education is peculiar to the young women who choose to enter our schools of nursing. Their sisters who go into the teaching profession are doubtless as unable to do fractions, to spell, to express themselves correctly. Thus a continuing round of ill-prepared children will emerge from our schools — children who have been permitted to choose at too early an age the subjects they wish to take and those, in which they are less proficient, that they can avoid.

Are there any solutions to this problem? Regular and repeated appeals to the provincial minister of education will draw his attention to the apparently low standard of education in the basic subjects found among girls graduating from high school. Efforts to stimulate the interest of public school principals in having their teachers coach and drill their pupils more diligently may help. Parent-Teacher or Home and School Associations would be active supporters if the problem were explained to them by representatives of the nurses' association.

Some schools of nursing have entrance tests in English and arithmetic. Even if these were not used as the basis of selection of students, they would give the schools of nursing a starting point from which they might pick up the threads of completing their students' basic preparation.

The three R's are still tremendously important. When parents realize that a life may hang on their daughter's ability to calculate the correct fractional doses in medications, they will get behind a nurses' campaign for greater stress being laid upon these aspects of basic education.

This problem exists. It has to be solved. Why not urge that it be faced from the first day in September when the child starts school?

Convey thy affection to thy friend, as an arrow to the mark, to stick there; not as a ball against the wall, to rebound back to thee.—FRANCIS QUARLES.

Trends in Pediatric Nursing

BRENDA CARTER, NANCY FRANKLIN *and* BETTY WOOLNER

NEW METHODS of treatment for many acute illnesses have resulted in greater numbers of convalescent children in the wards. Knowledge about growth and development has brought an understanding of what it means to nurse children on an individual basis. The concept of "total care" has made obvious the need for including the parents, especially the mother, in the plan of care. Through it, too, the hospital nurse has learned that her contribution is only a part of the whole, for often the services of a nurse and other workers in the community are necessary to complete and enhance what she has initiated. These and possible other factors have resulted in a "new deal" for children in hospitals. The story of Marie, as told by the head nurse, illustrates these trends in the care of children.

The admitting room nurse called and said that Marie, aged 18 months, was being admitted with a provisional diagnosis of pneumonia and that she was acutely ill. I selected the student who would care for the baby and assisted her to make preparations which included oxygen and suction.

When the mother and baby arrived at the ward, I spoke briefly to the mother asking her to wait to see the doctor and to see me when he had finished asking questions. I took Marie and put her in bed. I then called the interne, asking him to let me know when he had completed the history so that I might speak to the mother. He ordered a croupette to provide oxygen and humidity which I provided immediately. I discussed the care with the student and a few minutes later returned to the mother. She was quite upset and was crying. I tried to reassure her, taking her to the bedside, where I explained the treatment and pointed out that the baby was already much more comfortable. She seemed to be relieved that treatment had been started immediately and, after a short time, was ready to leave. I asked her to telephone the next morning to make arrangements with me about coming to visit.

In making a plan of care for this child, I needed to know about the child herself, about the social conditions, and about the illness. A questionnaire, used at the time of admission, gave some information about the child's behavior with regard to eating, elimination, sleep and play. The child had been fed exclusively on milk from a bottle, there had been no attempt to toilet train, and her life seemed to have been quite irregular.

This family of four—mother aged 21, father aged 25, Marie and her sister Lillian, aged 5 months—lived in a four-room dwelling in a congested workingman's district. The home consisted of three bedrooms, a kitchen, and bathroom with toilet and sink providing running water but no bathtub. One of the three bedrooms was occupied by a boarder who seemed to watch the babies on occasion when the mother went calling on a neighbor. The rent was $30 a month and the house looked clean but not too tidy. The father earned over $200 monthly, working at night as a maintenance man with the railroad. He came home in the morning, prepared his own breakfast and went to bed. Marie and the rest of the family usually got up at about 10:30, which meant that there were two meals a day.

Marie's illness began a week prior to admission when she became very irritable. Up until that time the mother felt that the child had been healthy, except for the fact that she had never eaten well and could not walk. Her respirations became rapid and she consistently refused to take either milk or water. She developed a bad cough and the mother brought the child to the out-patient clinic. A clinical diagnosis of pneumonia was confirmed by x-ray.

The plan of nursing care was based upon the following needs: Therapeutic

At the time this paper was prepared the authors were all staff nurses at the Children's Memorial Hospital, Montreal.

care; rest and sleep; airway; food and fluid; elimination; observation; hygienic care; emotional and social care—play; teaching of the mother.

During the acute phase, these were provided for as follows:

Intravenous by scalp vein was started and Marie was treated in bed in a croupette which supplied oxygen and humidity. Drug therapy was commenced and frequent suctioning of the nasopharynx for mucus was necessary to provide an airway and to prevent aspiration. We watched for increased respiratory distress, such as in-drawing of the intercostal muscles and sternal notch, which are signs of obstruction in the bronchioles or larynx. The ice compartment of the croupette was filled with ice to help reduce the elevated temperature. Thus the need for sponging for fever was reduced. Fluid was administered by intravenous for the first 12 hours, when the intravenous was discontinued and small amounts of fluid and milk were offered at frequent intervals. These were taken and retained. While the infant was acutely ill, we did nothing about toilet training. She was rather dirty on admission but we omitted the bath for a couple of days, at which time she was able to be removed from the croupette for a bed bath. Oil was used to cleanse the buttocks. The mouth was not touched, as mouth care was not necessary. Cold cream was applied to the lips. A small plastic doll was hung inside the croupette for Marie to look at. The mother came daily, spending a few minutes at the bedside. On the fourth day, Marie was removed from the croupette and was able to sit up in bed.

During convalescence she was kept in bed for two days since she seemed content to lie quietly. A small amount of food was offered at mealtime, three times a day. However, Marie was not interested in solids and we gave her milk from a bottle since she was accustomed to that at home. New foods were introduced gradually and particular attention was paid to the things she liked. These were offered at mealtime. Gradually Marie began to show considerable delight in food and in being placed in her high-chair for meals. She was soon eating well and taking orange juice and cod liver oil. We then decided it was time to omit the bottle from her noon meal and gave her milk from a spoon and small glass. At first she did not like this and took very little but we did not give her the bottle again at noon.

After a few days, we stopped the bottle feeding at breakfast. By this time Marie was taking solids well and was losing interest in bottle feeding. She was taking milk from a cup very nicely. Finally, she was on three meals a day with one bottle feeding at bedtime, since this appeared to give her considerable comfort emotionally.

The child became rather independent at feeding time and began to show interest in finger feeding and holding on to the cup. Then chopped foods were introduced slowly. I arranged for the mother to visit at mealtime, when she could see the child feeding herself with obvious enjoyment. Marie became quite active in her crib and we found it necessary to put her in the playpen, where she could crawl around and pull herself up. Since she was not accustomed to an afternoon rest, we usually found her wide awake after trying to settle her for a nap. She was placed in the playpen with her favorite toys while the other infants were sleeping. She preferred blocks and old magazines but did not concentrate on anything for long at a time. We observed that she usually had a bowel movement immediately after her noon meal. She was placed on the "toidy" daily at this time. She enjoyed her daily tub bath along with the assortment of plastic toys. She became a happy child and, as a result, the mother came less often.

I saw the mother several times when she came to visit and talked with her about the illness, its cause, the need for vitamins and solid foods which had been absent in the diet. At the time of discharge, I explained the diet to the mother and gave her a diet sheet to follow, with sufficient vitamins for one week, at which time she would return to the out-patient department to have Marie checked. Arrangements had been made by the nurse in that department to refer Marie to a well baby clinic for health supervision.

You will have noticed that emphasis was placed upon emotional aspects of care, the adjustment of hospital

routines to suit the individual child, and help to the mother. The need for care following hospitalization was brought out also. These aspects of care are important trends in modern pediatric nursing.

Care of Older Children

The care of older children in hospitals is changing also. No longer do they sit or lie in long, tidy, cheerless rows with uncongenial next-door neighbors and with nurses to say "sh—" every time the child opens his mouth because a staff doctor and his associates are making rounds. Routines are still necessary but are as fluid as possible. The child's background is known and we imitate his home routine whenever possible. Thus, an afternoon sleep is not enforced if he is unaccustomed to one. Instead, he is provided with suitable, quiet play facilities while the other children sleep.

Children of the same age, capable of the same amount of activity or speaking the same language, are placed together. Mealtimes are made as attractive as possible, using small tables and chairs and high-chairs, where essential, arranged in groups with a nurse in attendance. Some self-selection, some positive encouragement may be used but no nurse will stand over a small child with an expression on her face which says plainly, "You eat this, or else. . . ."

For play and occupation, children's beds are placed together and sharing of toys encouraged. These activities are organized largely by personnel from the play and occupational therapy departments. They provide toys, organize group games, and teach crafts. The nurse must do much to promote this work, by encouraging the children and by making their play possible, even in such a simple way as allowing little Johnny's bed to be placed next to Billy's, in spite of the fact that the "look of the ward" may be spoiled. School lessons are provided by qualified school teachers who assist the children for short periods daily at the bedside or in the schoolroom. Visiting hours are set but are altered, if necessary, for the individual child. Equipment consists of low beds to provide security and independence, with accessible lockers where a child may keep his treasures. As mentioned before, low chairs, tables, and high-chairs are necessary. Plenty of space between beds, floor space to play, and a playroom, where even rowdy games may be played on occasion, are essential. Separate rooms are needed for the seriously ill, for children on limited activity, for interviewing parents, or for conducting staff conferences. These staff conferences should be developed to include head nurse, doctor, social worker, special therapists and community nurse, when necessary. This should also make it possible to discontinue ward rounds with discussions at the bedside.

The teaching of personnel is very important and requires adequately prepared graduate nurses who, by their education and association with children, can appreciate the necessity of treating each child individually. A good pediatric nurse must be able to be a friend and companion to the child and the interpreter of his needs. To teach nursing students this point of view, the patient assignment method is used where each nurse has three or four children for whom she is entirely responsible. Students should not be rotated too frequently as children are sensitive to changes. It is a well known fact in a children's hospital that you can "hear" change day on the infant ward long before the ward is reached.

There is also the necessity of teaching all ward personnel, for the nurse who is constantly with the children must assist the doctors, technicians, domestic staff, medical students, and others in their approach to children. One misplaced sentence or deviation from the truth can shatter the security we have been working to provide for the child since admission.

The formation of good relationships with the parents is essential and there should be mutual understanding between parents and nurse.

SUMMARY

Trends in modern pediatric nursing emphasize the recognition of the child as an individual, the importance of respecting this and of planning his care on an individual basis. Formation of good relationships, involving child, nurse, parents, doctor and other workers, is stressed.

The importance of meeting emotional needs as well as physical is being stressed, as is the need for adequately trained personnel to accomplish this type of care. New considerations are being given to the actual physical set-up of the wards so that the environment may be more suitable for little people. The need for health teaching and for continued care after discharge from the hospital is being recognized.

Geriatric Nutrition

EDWARD J. STIEGLITZ, M.S., M.D., F.A.C.P.

GERIATRIC MEDICINE deals with the health of the aging as well as the aged. It must not be assumed to be limited to the care of the senile. Geriatric medicine is not a sharply defined specialty. Rather it is a point of view which takes cognizance of the physiologic, structural, psychological, and immunologic changes of continuing maturation. To age is to change. As aging begins at conception and terminates only with death, it is obvious that there can be no specific chronologic age where geriatric medicine should begin. It is significant that the chronic progressive disorders, characteristic of later maturity, not only start far earlier than their first overt clinical manifestations but, being endogenous, are intimately related to earlier nutritional status. Health in old age is predicated upon health in youth and through maturity.

Thus geriatric medicine in general and geriatric nutrition in particular demand constant attention to prophylaxis or an anticipatory attitude in order to fully realize their potentialities. The two decades from 40 to 60 are most significant. Aging changes vary widely in different persons. Even within a single individual, aging is not symmetrical; we are not the same functional (biologic) age throughout. Consequently, the clinician and or nutritionist dealing with the elderly is constantly confronted with great and often perplexing individual variation. General dietary rules must be individually modified more often than not.

Nutrition is more than diet. Proper nutrition includes not only ingestion of adequate and balanced quantities of all necessary nutritive elements but also digestion of foods, their absorption, transport to the tissue cells and utilization by the cells. Impairment of cellular nutrition may result from any one or more of several factors:

1. Inadequate nutritional supply (such as dietary deficiencies, digestive failure, oxygen lack due to anemia).
2. Inefficient distribution (cirulatory impairments).
3. Ineffective utilization of food elements (hypoinsulinism, asphyxia, enzyme deficiencies).
4. Accumulation of injurious metabolic debris (such as azotemia, uric acid deposition).

Malnutrition may thus be endogenous as well as exogenous. It includes excesses as well as deficiencies. As health is relative and never absolute, the potentialities of an optimal nutritional status are still unrevealed. In many respects the changes of senescence are consequences of cellular malnourishment.

Obviously, we cannot here discuss

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all the many changes consequent to aging which relate to nutrition. Equally clear is the fact that the basic needs of human nutrition and metabolism are not altered fundamentally throughout the life span. However, certain significant aspects of aging which affect nutrition during senescence are worthy of brief emphasis.

The increasing divergence which occurs with advancing age has already been mentioned. This variability primarily stems from the fact that no two people live identical lives or have been subjected to identical experiences. The mature are what they are largely because of their yesterdays; the older one becomes the more yesterdays have occurred to affect us. The inevitable vicissitudes of existence, such as intoxications, infections, fatigues, and nutritional, physical, and psychological traumata, are never identical in content, severity, or sequence. Many of the injuries acquired in the course of living are truly unavoidable inasmuch as they stimulate the development of compensatory and protective mechanisms. Nevertheless, every toxic, psychic, traumatic, or biochemical injury leaves some residue of scarring behind. The detriment is more often than not undetectable but the insidious cumulative effects are considerable.

Changing Metabolism

In man, the rate of metabolism diminishes with age. Perhaps it is significant that the basal rate is the only physiologic constant for which we make a correction for age in calculating the normal. Assumption that decline in metabolic activity is necessarily desirable is not warranted. Just because it is common does not prove it to be optimal. We have long known that most persons tend to gain in weight after the peak of growth but it is only recently that statistical studies have revealed that such gains in weight after 25 affect longevity adversely. However, whatever the theoretical implications, the fact remains that the rate of metabolism *does* fall with age and thereby affects nutrition in several ways:

1. Reduction in caloric requirements (involving that most difficult task: alteration of eating habits).
2. Consequent obesity.
3. Interference with cholesterol catabolism and, therefore, encouragement of hyperscholesterolemia so significant in the genesis of arteriosclerosis.
4. By increasing obesity and arteriosclerosis raising the incidence of late diabetes mellitus.

Habits of eating play a most significant role in nutritional problems. Habits are probably one of the greatest obstacles in the path toward obtaining an optimum diet by the majority of persons. Habits may last longer than life itself, for they may be transmitted from one generation to the next. It is extremely doubtful, for example, whether obesity is primarily an inherited characteristic in the purely genetic biologic sense. The child who grows up in a family where the parents are obese by reason of overeating acquires the habit of eating excessively. The longer habits have been indulged in the more rigidly they become fixed.

Water

The practice of ignoring water as an element of diet is to be deplored. Unfortunately, in many discussions of nutrition, consideration of water is omitted. The total intake of beverage fluids should be such that the 24-hour urinary volume is a minimum of 1,500 ml. In hot weather this may mean fluid intake of 3 liters or more but in ordinary cool weather, with moderate activity, an intake of approximately 2 liters is optimum. In the older person it may be desirable that the fluid intake be spaced, with small amounts taken at relatively frequent intervals rather than large quantities at any one time. Water is vital not only for urinary excretion but to avoid constipation and assist the weakened digestive processes.

Calcium

With advancing age, it becomes increasingly difficult to maintain a positive calcium balance. Loss of calcium from bone leads to osteoporosis and

the serious fragility so frequently responsible for fractures. Lowered gastric acidity, hepatic and pancreatic insufficiency contribute by impairing calcium absorption. Depreciation of the androgenic and estrogenic (sex) hormones with age contributes to the deficiency because of their significant anabolic activity. The dietary calcium requirements of older persons are much higher than those established for young adults.

Protein

The elderly are prone to suffer from protein starvation more than any other form of deficiency. Inadequacy of protein is a significant factor in the pathogenesis of tissue wastage, anemia, bone atrophy, and edema. Mild deficiencies may be manifested primarily by a sense of habitual fatigue. Unfortunately, the majority of older persons dislike or resent the prescription of milk. Milk is not only a valuable source of protein but also a major source of calcium. Skim milk may be preferable to whole milk as a source of extra protein, especially if one wants to avoid increasing the fat intake. Other significant sources of protein are cheese and lean meats, particularly if they are properly chewed. The requirements of the older person are similar to those of a younger person — namely, a minimum of 1 gram of protein per kilogram of body weight per day. However, many elderly patients are in a state of negative nitrogen balance and ingestion of 2 grams of protein per kilogram of weight may be necessary to produce a positive balance.

Anemias

Anemia, even of relatively minor degree, constitutes a serious handicap to health in later maturity. Whenever there occurs an impairment of the circulation, such as the impediment offered by narrowed, tortuous arteriosclerotic arteries or the spastically constricted arterioles of hypertensive diseases, the quality of the blood becomes proportionately more significant. The circulation in the elderly cannot accommodate by an increased flow as well as in younger persons. Therefore, any reduction of the hemoglobin content below optimum levels warrants attention. It is characteristic that the anemias of the elderly are usually due to a combination of nutritional deficiency and impairment of hematapoesis. They are simultaneously "primary" and also "secondary" and corrective therapy must take both forms into consideration. Not infrequently, response is poor until a state of depressed thyroid activity is corrected.

Summary

The essentials of good geriatric medicine must include consideration of the following basic principles and factors:

1. Individualization in dietary prescription.
2. Recognition of the role of habits and that their modification be gradual.
3. Water intake adequate for the urinary system and for proper functioning of the alimentary tract.
4. Soft bulk sufficient to avoid constipation.
5. Caloric intake adjusted to requirements as modified by lowered metabolism and lessened activity.
6. Calcium sufficient to maintain a positive balance.
7. Close attention to protein intake, with a minimum of 1 gram per kilogram per day.
8. Awareness of the need for adequate iron and vitamins to prevent or correct even minor degrees of anemia.
9. Palatability and digestibility of foods appropriate to an atrophic digestive apparatus and relatively poor appetite.
10. Good nutritional guidance throughout youth and maturity. An attitude of anticipatory, constructive prophylaxis is essential to effective geriatric medicine.

Knowledge concerning geriatric nutrition, both as to the specific requirements of the elderly and as to optimum nutrition prior to senescence, is as yet fragmentary and woefully incomplete. For example, at present we do not know whether the requirements for vitamins are altered by aging. There is urgent need for extensive research in these areas.

Cellular nutrition, in its broadest sense, probably holds the key to understanding the genesis of senescence. However, despite the obvious inadequacy of our present knowledge, there is room for better application of the little already known. There is much to be done.

Common Allergic Disorders

C. H. A. WALTON, M.Sc., M.D., F.A.C.P.

ALLERGY HAS BEEN shown to account for many medical syndromes, previously misunderstood. It has been invoked often and still continues to be invoked to explain many medical mysteries. It has done so in some cases but it must not be used as an easy and uncritical way out of a difficulty. Clinical allergy is common and its careful management produces worthwhile practical results. As in all diagnosis, thinking of the possibility of allergy is the first step in its diagnosis.

Diagnosis in allergy is the recognition of a syndrome in which allergy is likely to play a major role or even an associated role. A serious attempt must then be made to identify the agent or allergen to which the patient is reacting and appropriate action taken.

ALLERGIC DISORDERS OF THE SKIN

The three commonest skin manifestations of allergy are urticaria (angio-edema), atopic dermatitis (eczema), and contact dermatitis. I believe that urticaria and angio-edema might be classed together for practical purposes. They vary clinically only in degree.

Urticaria is usually considered to be primarily allergic. Often there is a marked psychogenic factor particularly noticeable in the precipitation of an acute episode. Pathologically and clinically there is no difference between demonstrable allergic urticaria and so-called neurogenic or psychogenic urticaria.

In the latter type no allergic factor can be recognized and the psychogenic factor appears to be primary. However, it should be pointed out that, because an allergic factor is not demonstrated, it does not follow that such a factor does not exist and every effort should be made to find it. It is too easy and too glib to label a case psychogenic when in reality the physician has overlooked or failed to find the allergic cause. There is probably an endocrine factor in some cases of urticaria as evidenced by the variations in the disease during menstruation, pregnancy, the menopause and so on. Quite probably foci of infection also play a part in some cases. (Such foci as dental abscesses, etc., are often important. This might be taken as an example of intrinsic allergy.)

Urticaria is most often due to ingestant allergens, chiefly food and drink but often including such common drugs as aspirin and the barbiturates. Urticaria also occurs in some instances with inhaled allergens such as pollen, dust, animal dander, etc. In addition, it is caused not infrequently by injected allergens such as penicillin, the other antibiotics, liver, insulin, etc.

The urticarial reaction takes place in the cutis and it is characterized by an extravasation of fluid with eosinophil accumulation. The appearance of the lesions varies considerably and is easily recognized. Dermographia is often found with it and swelling of the joints is sometimes seen and is often painful. Any joint may be involved. The small joints of the hands and feet are those most commonly affected.

If it is recognized that urticaria and angio-edema are essentially allergic

diseases then the physician is more apt to make a diligent search for the offending agents. When these agents are found treatment is simple because the patient and the agent can be separated. If the offending agent or allergen is not found the only recourse left is to treat the patient symptomatically. Often this is most discouraging.

In considering the differential diagnosis of urticaria it should not be forgotten that insect bites such as those of the bedbug can reproduce lesions that are almost indistinguishable from urticaria.

Atopic dermatitis or eczema is primarily allergic but secondary changes often develop in the skin because of associated scratching and infection. Characteristically, this disease is seen most commonly in infants but it may be seen at all ages. The term infantile eczema is apt to mislead one into believing that the disease occurs only in infancy. It is true that in many cases the disease resolves spontaneously at about the age of two but in a fairly large number it may persist throughout childhood and even into adult life. The allergic agents are most often ingestants and food is, of course, the chief offender. However, not infrequently inhalants also play a considerable part. This is most typically seen in so-called ragweed dermatitis. The inhaled or ingested allergen reaches the skin via the circulation. The lesion is not exudative unless secondary infection occurs but it may exfoliate and often shows lichenification. The lesions are characteristically found on the flexor surfaces of the extremities, the face, and the breast. Clinical experience has shown that very often atopic dermatitis has an associated contact factor—that is to say, while the primary allergen reaches the skin via the circulation, contact allergens such as wool and other irritants may add considerably to the problem. Local treatment may be directed towards protecting the skin, combatting infection and giving symptomatic relief to the itching. The primary duty of the physician is to find, if possible, what allergen or allergens are causing the trouble and to remove them from the patient. If this is done the skin heals extraordinarily rapidly. When the allergen is again exhibited the skin breaks down most dramatically.

Contact dermatitis. The third commonest allergic disorder may be called contact. Dermatologists reserve the term allergic dermatitis for this particular type to contrast it with atopic dermatitis or eczema. The name implies a local skin reaction to the allergy. Perhaps the most commonly seen is that from poison ivy. However, there are many agents which will cause dermatitis—for example, cosmetics particularly nail polish, white metals as seen in costume jewellery, cigarette lighters, metal on garters, etc. Obviously treatment of this condition resolves itself into discovery of the offending agent and removing it. Recovery is usually rapid.

Gastro-intestinal Allergy

Allergic reactions can occur in any part of the alimentary system from the mouth to the anus. There is reason to believe that some forms of stomatitis are due to direct allergic stimulation. If the stomach or the upper part of the small bowel are involved severe dyspepsia, vomiting, and other manifestations occur. Not infrequently such symptoms as abdominal pain, chiefly colic and diarrhea, particularly when associated with large amounts of mucus in the stool, are due to food or drug sensitivity. All doctors are familiar with the patient who will develop sudden violent crampy abdominal pain, sometimes with vomiting and often troublesome diarrhea without apparent reason. Obviously such a patient may be suffering from a variety of pathological processes. Such diseases, because of their seriousness, must be ruled out in the usual way. However, when all examinations fail to reveal an inflammatory, mechanical, neoplastic or other organic cause and when there is no psychogenic disturbance apparent it should be remembered that allergy can cause these symptoms too. Allergy is probably a common cause of gastrointestinal symptoms. If all other diseases are

ruled out and if allergy is thought possible, allergens must then be searched for and handled in the usual way by eliminating them from the diet. Foods and drugs are the usual offenders.

Finally, *pruritus ani* not infrequently is due to food sensitivity and it is very gratifying when discovered because the patient may then be saved much discomfort. It must not be forgotten, however, that *pruritus ani* may also be due to a variety of other causes.

Before leaving the gastrointestinal tract, it is probably proper to say that allergy has been thought to play a part in the etiology of ulcerative colitis. The behavior of this disease would lead one to suspect allergy and some observers have felt that they could demonstrate food allergy. I have never been able to do so and it is doubtful whether with our present methods we can hope to invoke allergy in helping us manage this very distressing illness.

Another disease which should be mentioned, not because it is common but because of its importance, is the *Schönlein-Henoch syndrome*. This syndrome involves the skin with a purpuric rash, the intestinal tract with signs of severe regional ileitis, the renal tract with signs of nephritis, and the joints. It is often demonstrably allergic in origin and, of course, if this can be demonstrated a great deal of help can be given to the patient.

The Central Nervous System

Migraine is a very common disorder and it is frequently attributed to allergy. This disease is so difficult to treat symptomatically and is so discouraging to manage, that it is highly desirable to remember that allergic factors can be demonstrated in as large a percentage as one-third because if they are demonstrated management becomes very simple. Perhaps the commonest offender in migraine allergy is chocolate. It has been suggested that Ménière's disease may be allergic in some instances. This suggestion has not been widely accepted and has been rarely demonstrated.

The Genito-urinary System

Urinary frequency very occasionally is traceable to an allergic reaction. I have seen one case with an urticarial reaction in the bladder mucosa which responded immediately to antihistamine drugs. It has been suggested that perhaps such entities as enuresis may have an allergic background but one would hesitate to stress this point other than to draw it to attention. Renal colic may, in rare cases, be allergic in origin. In the *Schönlein-Henoch syndrome* albuminuria, hematuria, and dysuria are features and, as has been mentioned, are frequently allergic in origin.

The Hemopoietic System

It is now becoming rather widely accepted that agranulocytosis and acute hemolytic anemia are due to the development of allergy to drugs such as amidopyrine.

The Respiratory System

I have deliberately left consideration of this system to the last because of its very great importance and its frequent allergic involvement.

Allergic rhinitis or hay fever is characterized by periodic, severe nasal obstruction, marked sneezing, rhinorrhea, itching of the nose, eyes, palate, etc., and in appearance by a pale, wet, swollen nasal mucosa. This disease may be strictly seasonal as with pollinosis or it may occur throughout the year. While allergic rhinitis is a very unpleasant disability, it does not assume serious proportions unless one realizes that it very commonly precedes asthma. It is my experience, and that of most observers, that as many as 50 per cent of cases of allergic rhinitis will develop bronchial asthma sooner or later. Allergic rhinitis is most commonly due to inhaled allergens but it also occurs very commonly with food and drug sensitivity. It is to be distinguished from vasomotor rhinitis in which the mucosa is reddened and not swollen or wet and in which the secretion is not predominantly eosinophilic. The latter is a vasomotor phenomenon and it is very doubtful if allergy is involved in its

etiology. Allergic rhinitis is most commonly confused with the common cold and sinus disease.

The lesion in allergic rhinitis is due to increased capillary permeability which causes great edema of the mucosa and usually leads to a very watery, sometimes mucoid, and copious secretion. The secretion contains but few cells and most of these are eosinophils. There are very few pus cells. If the edema persists for a long time polypoid mucosa results. These polyps may become quite large and act as mechanical obstructing agents. I believe that it is very important that polyps be recognized as being probably allergic. It is well known that their removal is but of temporary benefit and if the primary allergic process can be arrested, the management of polypi becomes rather simple.

Bronchial asthma is probably the most important of the common allergic disorders. In my opinion it is always an allergic phenomenon although the allergic nature of a particular case may not always be demonstrable. Some observers have used the term "non-allergic asthma" to include this particular category, others "intrinsic asthma" or "infective asthma." It is true that one-quarter to one-third of cases of asthma cannot be given an undoubted allergic diagnosis with the means at our disposal but if it is borne in mind that all cases of asthma are probably allergic then the large group at present undiagnosed may be made smaller as our knowledge progresses. It is fair to say that because there is such a large group in which the allergic basis cannot be demonstrated physicians are inclined to assume that few, if any, cases of asthma are truly allergic and in this way they avoid making an etiological diagnosis which may otherwise be possible. It seems to me particularly important to stress this point because if an etiological diagnosis cannot be made the case becomes one for symptomatic management only and this is notoriously disappointing and difficult. Those cases which probably number two-thirds of the total in which a distinct etiological agent or agents can be demonstrated are relatively simply managed by control of the allergic factor. Pathologically there is no demonstrable difference between the case of known allergic etiology and the case in which such an agent has not or could not be found.

Today we have a reasonably good idea of the pathology of bronchial asthma. Essentially the disease is due to obstruction of the bronchi. This obstruction is due to swelling of the mucosa, to edema, and to an outpouring of a thick, viscid mucus containing many eosinophil cells. Mucosal edema and mucus plugging cause the widespread bronchial obstruction. The bronchial wall may be thickened by edema and in a few instances by smooth muscle hypertrophy. I doubt if bronchial spasm is an important feature in producing obstruction. Ordinarily inflammatory processes are not striking. Bronchial asthma is not an inflammatory disease. This is an important consideration because it permits acceptance of the conception of complete reversibility. When the allergic reaction has subsided the tissues return to normal. This fact accounts for the very striking changes seen clinically. A very severe asthmatic case may within a few hours present no physical signs of any kind, owing to the complete resolution of the allergic process. This striking recovery is not limited to the mild cases and is often seen today when using ACTH and Cortisone.

If the process is long continued the bronchial obstruction may permit secondary infection or bronchial stenosis and more commonly emphysema. Probably the commonest cause of emphysema is bronchial asthma. This is not to say that emphysema may not be caused by other pathological processes, particularly in degenerative processes as seen with advancing years. When it is realized that emphysema is the common and serious complication of asthma, that it may occur in childhood or early adult life, it is realized that it is indeed an important complication of this disease.

Pathologically hypertrophy of the right ventricle of the heart is very

common but *Cor pulmonale* in asthma is less commonly recognized clinically. However, it does occur and may be the final cause of death. The pathology of bronchial asthma has been studied in life by means of the bronchoscope and various functional procedures. A large number of cases dying in an attack of bronchial asthma have now been studied at autopsy and the findings are uniform. The pathological picture seen in the so-called intrinsic, infective or non-allergic asthma is no different from that seen in the true allergic or demonstrably allergic asthma. If the pathological and allergic concept is correct the time-honored diagnosis of chronic bronchitis with secondary asthma or bronchial spasm is no longer tenable.

The Differential Diagnosis of Bronchial Asthma

Bronchial asthma is a form of dyspnea which is usually paroxysmal in type and is characterized by prolonged difficult expiration, wheezing, and by severe cough. Asthma is reversible. It is a manifestation of allergy or hypersensitivity in many and it is often associated with other allergic manifestations such as hay fever, urticaria, eczema or migraine, either in the patient or in close relatives. The disease occurs at all ages from early infancy to old age and is about equally distributed between the sexes. It is more frequent in the male in childhood but in the reproductive ages the disease is about twice as common in women. In the aged the sex incidence is about equal. Characteristically the symptoms start abruptly, very often during the night, and they end equally abruptly. Cough is often the first striking symptom, particularly in childhood but often, too, in the adult. Wheezing and dyspnea may not be noticed until later. A persistent severe cough with little or no sputum (mucoid) in a child or in an adult, and for which no adequate cause can be found, must be considered as possibly allergic. Sooner or later characteristic signs may be elicited. In this connection it is important to emphasize that the characteristic expiratory rhonchi can often be demonstrated by causing the patient to inhale forcibly.

While asthma may be persistent for weeks or months in long standing and severe cases, it is ordinarily a periodic disease with striking remissions and exacerbations of abrupt nature. Often the symptoms are strikingly seasonal or episodic in character. The acutely ill patient may appear surprisingly normal within a few hours of an attack. Sputum is often scanty, is never purulent, and blood tingeing is uncommon. It is characteristically tough, tenacious, and hard to raise. The patients are seldom febrile except in early childhood and there are none of the common general signs of infection such as malaise, etc. Pallor, sweating on exertion, local muscle pain in the chest are, of course, common. Cyanosis may be striking. Of course, an asthmatic may develop intercurrent respiratory infection with all the usual signs.

On examination the chest is hyperresonant and moves as a massive unit. Vesicular breath sounds are poor or absent. Expiration is prolonged and expiratory rhonchi are prominent throughout. Rhonchi may also be heard on inspiration but are not as striking or prolonged. Moist rales are seldom heard except in complications and in localized disease of the lung. Blood eosinophilia is usually in excess of 4 per cent. Frequently the asthmatic attack is preceded by a "cold" which turns out usually to be an allergic rhinitis.

The allergic diathesis is markedly hereditary and asthma, therefore, is a markedly hereditary disease. It occurs commonly in families having asthma and other allergic manifestations. The presence of allergic disease in the family is a strong stimulus to finding it in other members of the family. As asthma is a manifestation of a constitutional diathesis, namely allergy, it is important to emphasize that other diseases of the respiratory tract may supervene. There is no reason why an asthmatic cannot have pneumonia, bronchiectasis, tuberculosis, bronchogenic carcinoma, lympho-

mata or heart disease. These diseases are not infrequently seen in asthmatic patients.

In the diagnosis of asthma the history is perhaps of the greatest importance. Too often the patient tells a garbled story of cough or dyspnea, bronchitis or chest colds but in the absence of actual pulmonary signs the doctor is apt to pass it off lightly as a neurosis or some vague entity such as tracheitis, too much smoking, etc. The diagnosis of asthma and, of course, this term includes the diagnosis of the cause of the asthma, demands an accurate record of dates, times, and the circumstances of each attack. The presence of other allergic phenomena such as hay fever, urticaria, atopic dermatitis, either in the patient or his family, is of great significance. Most asthmatics learn instinctively to exhale as gently as possible so as not to precipitate cough. If this is remembered the patient who has no gross signs in his chest should be caused to exhale forcibly. If he will not do this he should be exercised so that the increased respiration will produce signs which otherwise might be missed. Another useful diagnostic point is to give the patient a suitable sympathomimetic drug, such as ephedrine, with instructions to take it when he has symptoms. He will quickly note if benefit occurs. This is most suggestive. However, it must be realized that heart failure may also be benefitted by such a drug.

Differential Diagnosis

In infants up to two years the most difficult differentiation is between asthma and bronchopneumonia. Asthma is characterized by being recurrent, with or without moderate fever. The illness is brief. The response to medication is striking. There is often a family history. The infant may have eczema. Thymus enlargement may sometimes be wrongly credited with the symptoms. A foreign body, of course, must be thought of and tracheobronchitis with all its risks is a serious problem.

In the pre-school child the greatest difficulty arises in differentiating pertussis, pneumonia, bronchitis, and foreign body. In the school age child there is usually little difficulty.

In adults it is usually not difficult to distinguish true bronchial asthma. Of course, it must be distinguished from bronchitis, tuberculosis, rheumatic heart disease, hypertensive heart disease, and mediastinal tumors. The differential problem in older adults is somewhat similar.

A paraphrase of the Twenty-fourth Psalm by Charles Jarrell, adapted and dedicated to the graduate nurses:

"The hospital is the Lord's
And the operating rooms thereof
The wards and they that dwell therein.
For He hath founded it in loving kindness
And established it upon the mercy of Christ.
Who shall ascend into the house of health?
Who shall serve in the holy places of healing?
She whose hands have been made surgically clean,
And in whose heart is the pure love of Truth.
She who hath lifted up her heart unto service
And dedicated her life to the ministry of healing.
These shall receive the blessing.
They shall receive honors from the Lord,
They shall receive affection from all mankind."

The proportion of men employed in old age varies according to occupation. Non-agricultural workers begin to withdraw from the labor market in appreciable numbers not long past age 60, whereas the proportion engaged in agriculture does not lessen until 75. It is, therefore, not surprising that farmers and farm managers constitute the largest occupation group among men at 65 and over. The self-employed and managers also feature prominently at these ages. Similarly, jobs requiring experience and craftsmanship provide a frequent source of gainful employment for the older worker. On the other hand, older men rapidly drop out of the hazardous occupations and those requiring strenuous physical exertion but many continue in lighter work on a full-time or part-time basis.

— *M.L.I.C. Statistical Bulletin*

The Two-Year Plan Evaluated

DR. A. R. LORD

A DETAILED REPORT, issued in June, 1952, by a Joint Committee of the Canadian Education Association and the Canadian Nurses' Association, has found that nurses can be trained at least as satisfactorily in two years as in the usual three years but only if some new source of revenue can be secured. In such a scheme hospitals would be used to provide only enough clinical experience for training purposes; more graduate nurses and other paid personnel would be required; and a larger part of the cost of nursing services would be paid for in money instead of in student services. On the other hand, a shorter course and much better conditions of training might be expected to increase the supply of nurses.

An experimental two-year "Demonstration School of Nursing" has been in operation since January, 1948 in Windsor, Ont., under the supervision of the Canadian Nurses' Association and financed by the Canadian Red Cross Society for a four-year period. As an independent school it had its own Board of Directors and was associated with the Metropolitan Hospital for clinical practice. With the approaching end of the experiment in October an evaluation was a necessity and this was arranged through the cooperation of the Canadian Education Association.

The Joint Committee included: Dr. J. G. Althouse, Chief Director of Education, Ontario; Sister Denise Lefebvre, Institut Marguerite d'Youville; Miss Evelyn Mallory, director, School of Nursing, University of British Columbia; Mr. Allan McCallum, Deputy Minister of Education, Saskatchewan; Miss Agnes Macleod, director of nursing, Treatment Services, Department of Veteran Affairs; Dr. A. J. Phillips, National Cancer Institute of Canada; Miss E. K. Russell, director, School of Nursing, University of Toronto; Miss Helen McArthur and Miss Gertrude M. Hall (president and general secretary, Canadian Nurses' Association); Dr. H. P. Moffatt and Mr. F. K. Stewart (president and executive secretary, Canadian Education Association). Dr. A. R. Lord, Vancouver, was named director of the evaluation.

The absence of any considerable uniformity in the programs required by hospital schools of nursing and of any generally accepted criteria for measurement made two steps necessary in this evaluation. All relevant information was first secured concerning the Windsor school, followed by similar data for three "control" hospital three-year schools and comparisons were drawn. Two "control" schools were in large Ontario cities, one was in Saskatchewan, and all were highly recommended by provincial authorities.

Between admission and graduation the Windsor school lost 9 per cent of its students—"control" schools 21 to 30 per cent. The reasons were: Windsor—"unsuitability"; "control" schools—"dislike of nursing," "unsuitability," "ill health." Absences, because of illness, were fewer in Windsor and available time for study and for recreation was much greater.

Wide differences in content of curricula made comparisons difficult but all graduates must clear one last hurdle—Registered Nurses' examinations. Windsor's over-all average was 76.4% and "control" schools 69.7%, 70.5% and 70.7%.

Some subjects are optional for nursing schools. Among these are mental health, public health, psychiatric nursing, and tuberculosis nursing. In one "control" school none was available, in another about one-third received psychiatric training, and in the third, either psychiatric or tuberculosis nursing could be taken. In Windsor all four were compulsory and the use of mental health and

public health principles in all aspects of nursing was a significant aspect of the program.

Clinical experience is, of course, the most important part of a nurse's training. Supervision and repetition must make this thorough and it must deal with a wide variety of medical conditions and surgical procedures. More important still is the degree of integration which is provided between theoretical instruction and practice. The report points out two reasons why these aims were much more easily realized in Windsor than in three-year schools. The latter must give first consideration to the nursing needs of the hospital while the former is concerned first with providing the right type of practice. Also Windsor had two classes to schedule at any time while "control" schools had always six, thus providing a problem which was impossible of solution.

All students in Windsor received the same amount of experience in each major clinical field and, very largely, the same types within each field. Practice was carried out under constant and thorough supervision and was so closely integrated with theory that the two were seldom more than a day or two apart. All "control" students received about the same total amount of practice but there were wide variations, sometimes more than 50 per cent, within each clinical field. Supervision was excellent but theory and practice, despite considerable effort, were usually separated by several weeks and were even sometimes in different years.

The cost per year of training a student is about the same in each type of school—roughly $1,300. Hence each "control" school three-year graduate cost about $1,300 more than a two-year Windsor product. Payment is a different matter. In "control" schools students paid more than 75 per cent of these costs with their services and the hospital's "paying patients" met the rest. In Windsor students paid $50 per year in cash, probably $340 in services, and the Red Cross grant provided the balance.

The Joint Committee has issued its report as a purely factual statement of the development and program of the Windsor experiment but, because of the influence the School may have on nursing education, has added certain conclusions which have been reached. These include:

1. The average graduate of the Demonstration School, compared with the average graduate of "control" schools, is at least as well prepared for bedside nursing and better prepared for tuberculosis and psychiatric nursing.

2. The unusual educational values of the School are: a weekly student load which enables instruction to be by assignments and class discussion; close integration of theory and practice, a better preparation for advanced training.

3. Clinical experience is sufficient in amount and in variety.

4. The value of psychiatric experience is so considerable that its absence from a nursing school program is regrettable.

5. When a school has complete control of students' time, nurses can be trained at least as well in two years as in three, and under better conditions, but the training must be paid for in money instead of in service. Some new source of revenue is the only solution.

Rabies

Rabies is a virus disease, transmitted to man by the bite of an infected animal, usually dogs. Other important carriers are cats, wolves, jackals, and foxes, as well as the mongoose, meercat, and genet in South Africa, and the vampire bat in South and Central America.

Recent important advances in the study of rabies include the introduction of the mouse as an experimental animal for detecting the virus, the development of new and potent vaccines, and the use of hyper-immune serum in the prevention of the disease.

WHO has sponsored a series of rabies surveys in different countries, aided Israel in the vaccination of dogs, and assisted Mexico in a project involving vampire bats.

— *WHO Public Information Office*

Nursing Research

H. A. Goddard

Before we discuss the question of nursing research, it would seem appropriate to be quite clear in our minds as to what we mean by the word research. I say this because I am convinced that there is a great deal of confused thinking on this subject and I know of few words which are more loosely used.

To some people research is a frightening word, conjuring up visions of atomic bombs and awe-inspiring laboratory activities and, incidentally, for that very reason it is often used to impress people. A study of the advertisements for many patent medicines will bring home to you the fact that research covers a multitude of sins.

Defining Research

The Oxford dictionary tells us that research is "an endeavour to discover facts by scientific study"— a course of critical investigation. In other words, it is the orderly systematic collection of facts about a specific problem and the classification, analysis, and interpretation of those facts. There is, therefore, nothing abstract about research. It is a perfectly straightforward procedure and, although the subject matter of particular research may be highly technical in content and demand specialized knowledge, the basic principles upon which it is conducted are simple.

Before I enlarge upon these basic principles, however, there are one or two broad generalizations I should like to make. The first is about research workers — that is, the people who conduct research. The first essential, more important than anything else, is that the worker should have a perfectly open mind and be completely free from prejudice. This may seem to you to be stating the obvious but it is important to stress that those who undertake research work, in whatever capacity, must in their search for facts be willing to accept facts which may conflict with their own opinions and that is never an easy thing to do. In passing, I may say that I have often been taken to task for not employing nurses in the initial stages of the Hospital Job Analysis but, in planning that particular phase of the work, I felt that the ability to view the worker and the task with a completely unbiased mind was much more important than a complete technical knowledge of the jobs encountered. Indeed, as Dr. Sheldon points out in "The Social Medicine of Old Age":

> Too much knowledge may, in fact, be a handicap for under its pressure the mind find it only too easy to confine its vision to the things it has previously been conditioned to look for.

The Objective Approach

So, in the collection of facts, the first stage of any research project, the objective approach is the most important factor — technical knowledge comes later in the interpretation of the facts.

This leads me to a consideration of the two distinct types of research — "pure" and "applied" or, as they are sometimes called, "fundamental" and "action."

Pure or fundamental research seeks a knowledge of facts for their own sake and the people who take part in it are more interested in discovering "the truth" than they are with the subsequent use that is made of their researches. This is the point of view taken by most scientists who believe that the discovery and publication of the truth will, by the very nature of things, in due course bring about changes for the better. It is this type

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Mr. Goddard is director of Hospital and Public Health Job Analysis Enquiries, Nuffield Provincial Hospitals Trust. His address was given at a refresher course for nurse administrators and sister tutors at the Royal College of Nursing. It is reprinted with permission from *Nursing Times*, Journal of the Royal College of Nursing, London, England.

of research that has led to the popular belief that all research is abstract. Applied, or action, research has an entirely different primary purpose and the person engaged in it is not so much concerned with adding more truth to the sum total of knowledge which exists about this subject as he is in the improvement of the practices in which he is engaged.

He undertakes research in order to find out how to do his job better. There is a problem to be overcome and his whole attention is directed to this solution. Action research — I use the term in preference to the usual one "applied research" because I think it so aptly descriptive, means exactly what it says — is research that affects actions and, unless it results in useful findings, it is unsuccessful.

Both types of research use the same methods and techniques. They differ only in their aims and objectives and I think it is important, if we are later to discuss the value of research work so far as the nursing profession is concerned, that we should fully appreciate what that difference is.

The major difference between the pure research worker and the action research worker is that the former is a student of the phenomena observed while the latter is an active participant, a practitioner, in the activity being studied.

Pure Research

The former usually takes the line that his function ends with the discovery of the truth and that it is the responsibility of the practitioner to make practical use of his findings. Indeed he will probably tell you that his real value as an investigator lies in his aloofness from actual practice. This attitude may perhaps be better explained by following the sequence of events in a hypothetical project of pure research.

First, an interesting and frequently important question occurs to a group of investigators or a single research worker. Let us take as an example a social scientist who is studying adolescent development.

He wishes to learn more about the relationship between, say, football playing and the incidence of car-driving accidents. His hypothesis may be that the excitement and risk involved in playing football reduce the need for the excitement and risk that result from driving a motorcar recklessly.

The first step the investigator would take would be to make a thorough search of all the available literature to see what, if anything, other people had discovered and published about this relationship. If he found no answer to his question or one that he thought inadequate he would proceed to design and conduct an inquiry.

Now the point I am making is that in all probability our investigator would have no intention of doing anything with the results of his study beyond publishing them. He might not even be working with adolescents. In only a vague general sense would he feel any obligation to reduce the frequency of accidents involving adolescent drivers. He just wants to find the answer to a question that seems to him to be important and intriguing. Someone else may use his findings. He may even recommend that this be done in the last paragraph of his report.

He, himself, after he has interpreted and published his findings, will go on to other things. He is an investigator, not a practitioner.

Action Research

People who engage in action research do not make any such neat distinctions between the research function and the practice function.

In action research the investigator is more interested in the particular subject he is studying and less interested in the total theoretical quantity of which his subject constitutes a sample. The action researcher works in a specific, dynamic situation with specific and identifiable persons. In his studies he tries to find out whatever he must in order that a better job may be done.

In comparing the two types of

research work I am not suggesting that one is better than the other. There is clearly a need for both but it is important that we should recognize and understand the scope of each before discussing their respective uses in the field of nursing.

The quality of pure research and the quality of action research are judged by different criteria. The former is considered to be superior in the degree to which the methods and findings warrant generalizations being made beyond the persons and situations studied. For example, if the Hospital Job Analysis report produces findings which, based as they are on a sample number of hospitals, are, nevertheless, deemed sufficiently practical to warrant them being applied to all general hospitals, then the inquiry will have been successful. An investigation (fundamental) is a good one if it adds to the sum total of knowledge that is already recorded and available to anyone who wants to read it.

The value of action research, on the other hand, is determined by the extent to which the methods and findings make possible improvements in practice. Stating this criterion a bit differently, action research is justified when it adds to the practitioner's functional knowledge of the matters with which he or she must deal.

Research Methods

Having dealt with both types of research let us now review the methods used. I said earlier that there are certain basic steps necessary to the successful conduct of all research and I should like you to note them because I am sure you will find them useful as an aid to clearer thinking about your own particular problems. They are quoted from an article in *The American Journal of Nursing* (December, 1950) by Elizabeth La Perle, entitled "Research and the A.N.A. Program."

These steps, six in number, are: Definition of the problem; collection of facts; classification of facts; analysis and interpretation of facts; experimentation; statement of findings.

Finally, and although this is not counted as a step it is most important, the real success of a research project lies in the implementation of its findings.

Let me take the steps one by one.

A definition of the problem to be studied: This may sound obvious but it is one of the things which nearly everyone fails to do. The other day I was lunching with a medical superintendent of a large hospital in Scotland and he said to me, "I should like you to do a job analysis of my hospital." I said, "What for? What is your particular problem?" And he said, "Oh, no particular problem but I feel it might do a lot of good." Now that is just an example of what I mean by confused thinking. A few days ago I said on this platform that there was nothing magical about the words job analysis and the same remark goes for the word research. Whether your problem is one of work, of conditions, or of human relationships, it must be specifically defined before a course of action can be planned. You will find, too, that if you use this method with your own particular problems, the actual exercise of writing them down and specifically defining them brings them into a clearer perspective and often goes a long way towards solving them.

The collection of facts: It is essential that this is done in an orderly systematic way. So far as work situations are concerned, the job analysis method of fact-finding has much to commend it but the actual method of collection must depend upon the circumstances under which the inquiry is made. The two methods normally used to collect facts are: by direct observation and by questionnaire.

The former, which includes laboratory experiments and job analysis technique, is usually regarded as the most effective. The questionnaire method has certain advantages where a particularly wide sample is to be taken but great care should be exercised in planning the questionnaire which is a job for an expert in that field.

In the inquiries which I have been conducting both methods have been used and in the reports, which will be published shortly, a full description of the method employed is given.

Classification of facts: After the facts have been collected the next step is to classify and correlate them. This is usually carried out: (a) on the basis of similarities and dissimilarities; (b) on the basis of essential and non-essential characteristics; and (c) on the basis of causes and results.

Analysis and interpretation of facts: As a result of the classification of the facts the information thus gained is analyzed and interpreted and it is at this stage that expert knowledge is essential. I think that one of the most misleading statements ever made is the oft repeated one that "facts speak for themselves." You can take it from me that facts do not speak for themselves. They require interpretation in the light of expert knowledge and informed opinion. After they have been thoroughly sifted by that process it is possible for conclusions to be drawn and generalizations made with regard to the whole field studied. These findings may make all sorts of recommendations but if any positive change in existing practice is advocated then, before it is published, the next step, *experimentation*, is indicated. Those of us who have had experience in engineering know how often the blueprint, which looks so well on the drawing-board, finds unexpected obstacles when it is translated to the factory floor and the same is true of every other work situation. I ought to tell you that it had originally been decided to conduct practical experiments following the hospital job analysis inquiry but the demand for the report has been so insistent that we have decided to publish the findings in the form of suggestions which, it is hoped, will stimulate nursing administrators and ward sisters to conduct experiments on their own. In this way, it is hoped that widespread action research will test the validity of our findings in a much more universal manner than could have been done by our own experiments. We have tried to make our approach a realistic one, to give you not ideals but ideas—ideas which the nurses of this country can implement within the existing conditions under which they work.

I am sorry if I have digressed by talking about my report. I have really anticipated the final step in any research project, which is that of reporting the findings to colleagues and other interested bodies. This is an essential step if research is to have maximum usefulness.

Implementing Results

You will remember that I spoke of the extra step—beyond that of reporting—namely, the implementation of the results or putting the facts to work. This is a matter of paramount importance and should be considered and planned for from the inception of the inquiry or study. Too often a research study is carried out, findings reported and they lie unrecognized and unused. Only when the findings are used can the study be considered a successful piece of applied research. If they are not used, the undertaking is a waste of everyone's time, energy, and money. Implementation, if it necessitates change, will usually be a slow, evolutionary process, not sudden and revolutionary.

It is in respect of this last point that I particularly want to speak to you. There will shortly be published a report of the work which the Hospital Job Analysis team has been doing for the past three years. For obvious reasons I cannot talk about the contents of that report but I can say one thing. When I took on the task of conducting a job analysis of the work of the nurse I imagined that the publication of my report would see the end of the job. I realize now that it is only the beginning and that, unless research becomes an integral part of the profession of nursing, we cannot grow in knowledge and we are closing the door to opportunity. Planning without facts is guesswork. You as a profession must be prepared to adapt today's practices in order to meet the demands of tomorrow.

I hope very much that the report which I am presenting will stimulate the nursing profession to an appreciation of the need for continued research. The fundamental collection of facts—what do nurses do—has been completed and what is now needed is action research by nurses themselves. All sorts of problems come to mind immediately: the study of nursing functions in order to make more effective and economical use of nursing skills; the nurse's satisfactions and dissatisfactions on the job; her relations with other workers on the health team; how to make student status a reality; the relationships between what a nurse has been taught and her effectiveness on the job; the qualitative assessment of good and bad nursing—all these points need careful investigation. But that investigation must be directed and coordinated. Research, in isolation, can never be successful and, as I see it, the overwhelming need of the nursing profession is a permanent research body of its own. Too many people are engaged in telling nurses what they should or should not do. I believe it is the prerogative of the nursing profession to determine what its functions should be and I believe, too, that no other body can do the job well. In saying that I am not decrying the efforts, of which my own report is one, of outside bodies and, clearly, when the question of research is discussed some direction and training in technique will be needed. I still feel that the implementation of action research in nursing is more likely to become a reality if it is carried out by the nursing profession itself.

If a profession does not include research as part of its function it is not complete because it is only by research that the body of scientific knowledge peculiar to each profession can be built up.

Undoubtedly, there has been a great deal of research in the field of nursing but it seems to me that the difficulty has always been one of getting research data into action. There is available in books and articles a tremendous amount of information about nursing derived from research. The trouble is that the existence of this scientific truth, resulting from fundamental research, frequently has little, if any, effect upon practice. Even the nurses who hear about or read these reports are in most instances but slightly influenced by them. My plea is for action research, reinforced by experimental work designed to test and evaluate the effectiveness of the research. Then with the full weight of the profession behind them the findings can be published and the necessary steps taken to make those findings effective.

I said earlier that I had taken on the Hospital Job Analysis as a job of work. During the years which it has taken that job has become a crusade in which I wholeheartedly believe and which I should consider it a privilege to continue. I have tried to tell you what is meant by research, the steps which are necessary to carry it out, and its particular application to the nursing field and I firmly believe that the latter is not only a desirability—it is a necessity.

As a closing thought I leave with you a quotation from Lucile Brown's book "Nursing for the Future." In it she says, "Nothing short of permanent research, operating on a nation-wide basis, can provide the continuing factual data essential for the formulation of important policy."

In our society there is an abundance of sentimental talking and feeling about the aged but there is a comparative famine of time and effort in action. What action there is in Canada is still largely in the physical realm and to a lesser degree economic. The psycho-social factors, involving both psychological and social needs which are inextricably interwoven, are still in obscurity here.

Old age is not something that suddenly appears. It is an arbitrary term used to describe an ill-defined period in the process of aging, which begins at birth. This process is highly complicated and does not travel at the same rate for all persons nor, indeed, for all the organs and faculties of one person.

Annual Meeting Adjuncts

Held in Victoria the second week-end in May, the convention of the Registered Nurses' Association of British Columbia had several new features that gave a different atmosphere to the regular business sessions.

Full of interest to everyone was the Hobby Show with original work lent by the nurses for display purposes. Mary Kershaw has described this display for us. There were numerous other photographs which space would not permit us to include.

The excursions to Royal Roads and to the beautiful gardens are also described. Inexpensive to arrange, such entertainment as this provides a form of relaxation that makes the members enjoy going to conventions and, after all, attendance is important.

The Hobby Show

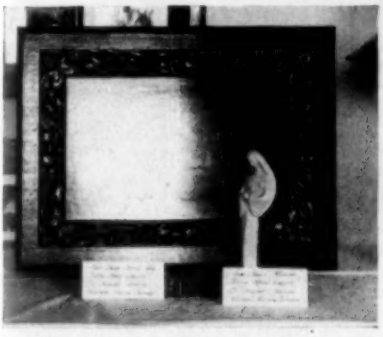
MARY KERSHAW

A notice was sent out to members of the R.N.A.B.C. through the chapters, inviting the nurses to send in entries to a Hobby Show to be held on the pre-convention day of the annual meeting in Victoria.

The response was most gratifying, with 104 exhibitors entering a total of 400 articles. No awards were made as this was in the nature of an experiment but the nurses discovered new interests and new ideas in the variety of displays from "dolls" to "spice sets." The Hobby Show proved that nurses *do* take an interest in outside projects other than "talking shop." Embroidery, crocheting, and knitting were in evidence and oil paintings, petit point, copper work, weaving, woodworking, and photography had a professional style. The collections included Miss Alice Wright's now famous collection of antique infant's feeding bottles and apparatus, dating from early 1700; a collection of china cats, old coins, silver spoons, and a colorful array of over 50 pennants. A pair of lamps, coffee table, footstool, and Madonna, hand-carved by Sister Mary Loretto of St. Joseph's Hospital, was very much admired. An un-

Royal Jubilee Hospital School of Nursing students.

The D.V.A. Nurses' Exhibit



Sr. M. Loretto's Wood-Carving

Nanaimo Nurses' Hobbies

usual hobby—orchids—grown by our busy arrangements convener, Mrs. C. B. Jameson, was an added attraction.

A cross-section of hobbies in general was entered by the nurses of Nanaimo Indian Hospital. The entry featured miniature felt-dressed dolls, depicting Indians in buckskin, Mexican figures under a felt palm tree, and a diminutive Moses in the Bullrushes. The student nurses of St. Joseph's Hospital and Royal Jubilee Hospital schools of nursing had fine displays, including Fair Isle sweaters. Nurses from the Department of Veterans Affairs Hospital also entered articles.

We are grateful to Dr. C. Duck, director of anesthesiology, Royal Jubilee Hospital, for the accompanying photographs. Photography is one of Dr. Duck's hobbies. The interest shown in the Hobby Show proved its success and all who participated agreed that it was "lots of fun and well worth the effort."

Since the centre of the room usually has a better circulation of air, a baby's cot should be placed there during the very hot weather. The infant will usually require three times as many drinks of water during the hot weather. The water should be at room temperature, never cold and, if at a summer resort where the water is not filtered, it should be boiled before being given to the baby.

In the past few years considerable progress has been made by the World Health Organization and by individual governments in promoting the health and longevity of peoples in some of the underdeveloped areas of the world. Our country has played a leading role in this effort. To advance the health of such peoples and to raise their standard of living is to further the cause of world peace.

Garden Tour

M. Fletcher

On Saturday evening, May 10, the most unusual event of the conference took place. It was a tour of some of the lovelier garden spots of the city.

we visited were of the rocky variety, with beautiful vistas of the sea and the snow-covered Olympics across the straits.

Our first host was Mr. J. G. Worth whose

B.C. Govt. Travel Bureau

Mr. N. Abkhazi's rock garden on Fairfield Road

Victoria is known as the "City of Gardens" and for one week every year the Horticultural Society arranges with local residents to have their gardens thrown open for public inspection. Fortunately, for us, the convention coincided with this week and we were most privileged to be granted a private showing of three of the loveliest gardens.

For those of you who have not been to Victoria, may I say that the city and its suburbs are surrounded on three sides by salt water and the coast has numerous lovely bays with rocky coastlines and hills rising here and there straight up from the sea. To the average gardener, this sounds like an insurmountable difficulty but not to Victorians. They fill every nook and cranny with earth and create an unbelievable display of color and variety of flowers and shrubs.

It just so happened that the three gardens

garden boasts of having a greater variety of flowers and shrubs than any other in North America. Each is said to be a perfect specimen.

The next stop was at the comparatively new garden of Mr. and Mrs. N. Abkhazi—a combination of rocks and flat areas. Remarking the beautiful colors in the rocks, we were told that, before making the garden, all the rocks were scrubbed with soap and water to bring out their natural beauty.

From here we went out to Esquimalt, to the lovely natural garden of Dr. and Mrs. T. McPherson. Here we saw a beautiful specimen of dogwood tree that is generally seen growing only in its wild habitat.

After touring the garden, we were guests of our charming hostess and host at their old family home, situated atop the hill and commanding a beautiful vista of sea, land and mountains—a fitting finale to a lovely evening.

Royal Roads

LAURA FOSTER

Have you ever strolled through a fairyland? Several visiting and local nurses, attending the annual meeting of the R.N.A.B.C. in Victoria, had this opportunity on the evening of May 10. Through the kind permission of the commandant of Canadian Services College *Royal Roads* we visited the delightful grounds and ancient castle.

First, we went across the spacious lawns to the Italian, Japanese, and rose gardens. The Japanese cherry trees were laden with their pink blossoms and, as we stood on picturesque oriental bridges, their reflection in the lake was a magnificent sight. Near here, also, the magnolia trees were arrayed in blossom along with the dogwood trees, B.C.'s provincial flower, which added much to the splendor of the gardens.

The next stop was the Cadet Block. Here, a naval cadet showed us the quarter-deck, chapel, and classrooms. From the Neptune stairs we watched the lowering of the flag, a most impressive sight which takes place every evening at sunset.

Then came the visit to the castle. Entering by the main door we visited the many spacious rooms of all four floors. We next climbed a spiral staircase to the roof which left us, I must admit, slightly short of breath but when we arrived at the top we were well rewarded by a view of all our surroundings—the green, velvety lawns, the multitudinous shades of blossoms, the three lakes in the gardens, and the wide expanse of ocean in the distance.

Yes, indeed, *Royal Roads* is a fairyland.

In the Good Old Days

(*The Canadian Nurse*—SEPTEMBER 1912)

"Wanted—head nurse for the infants' ward, Children's Hospital, Winnipeg. Salary—$50 per month."

* * *

"One solution to the problem of supplying nursing service to individuals of moderate means may be in the grading of nurses in a central registry according to the amount of training they have received and grading fees accordingly. Under such a plan, a doctor knowing his patient to be in a moderate income class may call the registry to supply a moderate-trained—i.e., having finished two years—nurse. The patient would be satisfied on receiving good value for his money; the doctor satisfied by not having expected faultless nursing; the nurse, satisfied in having given her best and received in return a specified fee; the higher graded nurse satisfied that the lower graded nurse has not imposed upon a domain which never rightfully belonged to her."

* * *

"Measles is as important a disease as scarlet fever. The deaths attributed to measles are three times the deaths attributable to scarlet fever. There is no doubt that measles does at least as much sum total damage as scarlet fever, although, case for case, it may perhaps be less harmful. Moreover, measles is four times as prevalent."

* * *

"It has long been felt that the probationer in the training school has a right to a more systematic, thorough training than she is getting. The instruction should be given by qualified nurse teachers and not by chance members of the medical profession, who could not be expected to know just what knowledge a nurse needs, nor even by nurses who have never qualified as teachers or have shown any aptitude to impart knowledge."

* * *

"It is the ultimate aim of the pioneers to establish Central Schools of Nursing on the same foundation as medical schools, with the use of various hospitals for practical work."

The derivation of the name of our country is a moot question. Some authorities have supposed that it came from the Iroquois word *Cantha*, signifying "a collection of huts." Other possible choices include the Algonquin word *Canatata*, meaning "welcome"; a Spanish word *Acanada* or "nothing here"; a Portugese word *Canada* indicating "narrow passage."

Nursing Profiles

The Canadian Red Cross Society has announced the appointment of **Florence H. M. Emory** as honorary adviser in nursing and chairman of the National Nursing Committee. In this capacity Miss Emory attended the 18th International Red Cross Conference held in the Royal York Hotel, Toronto, this past summer. She also represented the International Council of Nurses at these meetings.

A former president of the Canadian Nurses' Association, Miss Emory is associate professor of nursing in public health at the University of Toronto School of Nursing.

Randolph Macdonald Eaton's

FLORENCE EMORY

Frances Ulva McQuarrie has assumed her duties as assistant secretary at the National Office of the Canadian Nurses' Association. Born in New Westminster, B.C., of Scottish descent, Miss McQuarrie holds her B.A. and B.A.Sc. from the University of British Columbia where she majored in teaching and supervision in schools of nursing. A graduate of the Vancouver General Hospital, she has been supervisor of instruction at the University of Alberta School of Nursing for the past five years. Previously, Miss McQuarrie had held positions as head nurse, clinical supervisor, and science instructor in B.C. Following World War II she joined the nursing staff of UNRRA and assisted in the care of displaced persons in North Africa and Italy.

FRANCES U. MCQUARRIE

Jessie E. Young is the new director of nursing at Women's College Hospital, Toronto, succeeding Mabel Sharpe who has been acting director for the past three years. A graduate of the Toronto General Hospital, Miss Young holds her certificate in ward administration from the University of Toronto

Macdonald, Toronto

JESSIE E. YOUNG

School of Nursing and her B.S. degree from Teachers College, Columbia University. She served as head nurse and supervisor at T.G.H. until 1940 when she went to the Port Arthur General Hospital as instructor, later assistant superintendent. A year as educational director at the Hamilton General Hospital preceded her appointment as director of nursing at Kitchener-Waterloo Hospital in 1948.

Mary Alice Eleanor Ralph is now the assistant registrar with the Saskatchewan Registered Nurses' Association. A graduate of the Moose Jaw (Sask.) General Hospital, Miss Ralph secured her certificate in teaching and supervision from the University of Manitoba in 1944 and returned to her own school of nursing as nursing arts instructor. Since then she has been superintendent of nursing at the Community Hospital, Craik, Sask., head nurse in the pediatrics department at Providence Hospital, Moose Jaw, and assistant superintendent of nurses at her alma mater. She has served as president of the Moose Jaw Chapter of the S.R.N.A. and has also been chairman of the provincial Committee on Institutional Nursing.

In Memoriam

Carrie Louise Cherry, who graduated from the Toronto General Hospital in 1906, died in Toronto on May 16, 1952, after a brief illness. Miss Cherry served with the C.A.M.C. during World War I in England and France.

* * *

John Murray Gibbon, whose writing genius gave us, as co-author, "Three Centuries of Canadian Nursing," died in Montreal on July 2, 1952, at the age of 77. He was ill for only a short time.

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Eleanora Holwell Kirkby died in New Jersey on November 20, 1951, following injuries received when she was struck by a car. A graduate from the Hospital for Sick Children, Toronto, in 1906, Miss Kirkby went overseas with the St. John's Association Ambulance Corps, later transferring to the C.A.M.C. When she was demobilized in 1919 she went to New York where she engaged in private nursing until her fatal injuries.

* * *

Vera Alexandra McMahan, who was school nurse in Barrie, Ont., from 1927 to 1944, died recently in Midland, Ont. The Barrie Teachers' Council decided to assist in raising funds for the Canadian Arthritis Society as a memorial fund for Miss McMahan who suffered severely from arthritis following her retirement.

* * *

Bessie Gertrude (Jones) Morris, who graduated from the New York Hospital in 1923, died in Toronto on June 19, 1952, at the age of 50, following a lengthy illness. Mrs. Morris was on the Christie Street Hospital staff for some time. For the past seven years she had been matron of the Lockwood Clinic in Toronto.

* * *

Margaret Grace Murray, a native of Doaktown, N.B., who graduated from the Rhode Island Hospital, died at Neepawa, Man., on June 11, 1952, at the age of 83. Miss Murray worked in the United States before assuming the duties of superintendent of the Neepawa Hospital in 1919. Eight years later she enrolled at the McGill School for Graduate Nurses, taking post-graduate work in hospital administration. Subsequently she occupied executive positions in hospitals at Campbellton and Fredericton, N.B.

* * *

Emily Purton, a graduate of the St. Catharines General Hospital, Ont., in 1933, died on July 2, 1952, following an illness of only a few days.

* * *

Mary Eva Quigley, A.R.R.C., who graduated from the Vancouver General Hospital in 1910, died suddenly on June 26, 1952, at her home near Vancouver at the age of 65. Miss Quigley served in England, France, Germany, Egypt, and Salonika with the C.A.M.C. during World War I. She joined the Department of Veterans Affairs in 1921 serving at Shaughnessy Hospital, Vancouver. At the time of her death she was on retire-

ment leave from her position as nurse in charge of Hycroft Veterans Home.

* * *

Mildred Elizabeth Spreckley died at Camrose, Alta., on June 19, 1952, after a lengthy illness. A graduate of St. Thomas' Hospital, London, Miss Spreckley practised private nursing in Ottawa prior to World War I. She returned to England at the onset of that war in charge of the military ward of St. Thomas'. Later, she took post-graduate work in physiotherapy and went to Holy Cross Hospital, Calgary, soon after the close of the war as x-ray technician. She was in charge of physiotherapy at the Junior Red Cross Hospital and also conducted a private practice. During World War II she carried on physiotherapy at Colonel Belcher (D.V.A.) Hospital in Calgary, retiring in 1944.

* * *

Margaret Isabel Thirsk, who served overseas with the C.A.M.C. for three years during World War I, died in Toronto on July 2, 1952, at the age of 72.

Contribution of Nursing Services

Available in either English or French, the second report of the Expert Committee on Nursing, WHO Technical Report Series, No. 49, may be procured through *The Ryerson Press, 299 Queen St. West, Toronto 2B, Ont.*, for the sum of **15 cents.**

The all-important contribution of nursing services in meeting health needs and the problems involved in the provision of nursing personnel, particularly in those areas in which they are scarce or not immediately available, are discussed. Food, shelter, clothing, a healthy environment, ability to use available resources, and provision of care for the sick are recognized as universal prerequisites for healthy living. The nurse, an essential member of the health team, plays an important part in their attainment.

While the activities of a nurse vary greatly, she has four main functions to perform: (1) *psychological and sociological*—satisfying the emotional needs of patients and stimulating community movements aimed at improving health; (2) *operative*—providing care for the sick, assisting in childbirth, the rehabilitation of patients, etc.; (3) *educational*—as health educator of all with whom she comes in contact, as well as teacher of voluntary workers, auxiliary personnel, and perhaps other nurses; (4) *administrative and advisory*—helping to devise teaching programs and to plan and organize health services.

It is of paramount importance, when planning the provision of nursing services for the community, to take into consideration both short- and long-term needs, as well as the variation in types of services needed and in the resources available to meet them in regions of unequal development. Special care must be taken in the initial selection of nursing students in areas where the educational level of the people is low. Although schools of nursing should provide training sufficiently comprehensive to fit the qualified student to fulfil all aspects of the nurse's role—and not merely the actual performance of nursing techniques—curricula must be adjusted according to the general stage of development of the students and the communities from which they have been drawn.

The maximum contribution from nursing personnel in the establishment and maintenance of healthy peoples will be ensured if they are trained in relation to the functions they are to perform, are placed strategically at all levels in the health services, are incorporated in the health team with the full understanding of their potential contribution, are fully aware of the goals and objectives of the team and of their own part in achieving them and, above all, if they bring to their task the human understanding which is the essence of their contribution.

"We all start off at birth pretty much alike. But each year takes us farther apart from our contemporaries, until in the later years this phenomenon of individuality is at its peak. This is true of both the mind and the body and it is this which effectively nullifies many well-meaning, but ill-conceived, attempts to put hundreds of old people into a large building and 'treat them all alike.' Actually what may please and gratify one may torment and burden the next."

— Dr. W. E. Boothroyd in *Health*

Institutional Nursing

The Head Nurse

VELMA JOHNSTON

IT HAS BEEN stated that a head nurse is a graduate who gives the major part of her time to the management of a single ward and who assists in carrying out the ward teaching program. If this is true, and I think it is, "management of a single ward" suggests to me the main function of a head nurse—that of a hostess.

The patients are guests of the institution and as manager of the department the head nurse is their hostess. She should meet and welcome her guests and see that they are made comfortable. Very often the first interview, if friendly, can give the patient the feeling of confidence and security, which is so necessary if an effective health program is to be carried out and the patient made well. Great tact is necessary in getting the right patients together, as they should be grouped according to their personal needs providing there is no objection from the attending physician.

As hostess the head nurse must see that the patient's clothes are properly looked after and cared for; his flowers attractively arranged; his meals served as appetizingly as possible; and that diversions and entertainment are provided for those convalescing.

Her responsibilities as hostess do not end with the patient but rather are extended to include courtesies to visitors. Often this leads to a better understanding of the patient through his family and friends. They should be made to feel the human side of a hospital because it is the head nurse and her staff that interpret the hospital to the community.

Miss Johnston is a clinical instructor at the Hospital for Sick Children, Toronto.

Besides the patient, his family, and his friends the head nurse is also a hostess to the physician. When several doctors arrive at the same time it is impossible to give them all individual attention but it is the responsibility of the head nurse to see that they receive consideration and that their orders are carried out.

Other members of the staff, the superintendent, or the director of nurses may visit the ward. The good hostess meets each one and endeavors to keep them posted as to the happenings on her ward.

While receiving and caring for her guests, the head nurse, like a hostess in a home, must see that other activities in the household are going smoothly. She must see that duties are properly delegated to other members of her staff; that her domain is kept clean, well aired, and in order; that supplies are maintained and emergencies are met. She must have her day's work so organized that the proper proportion of time is delegated to each function according to its relative importance.

Besides being a hostess the head nurse must be an expert in her own field—nursing. She must know the subject of her own and related fields and not only know what skilled nursing is and how to give it but also how to provide such care for the patients in her unit. She should know each patient individually—their personal peculiarities and needs as well as their physical condition; their anxieties and discomforts as well as their treatment and progress; and know the community facilities available to help them with their difficulties.

She must study each patient and make a plan to meet his needs. When such plans are made by students she

should evaluate them and make the necessary adjustments. It is then her responsibility to see that this care is carried out consistently and efficiently.

In order to see that intelligent care is practised she must be familiar with all techniques and procedures. This is essential as she will be called upon to demonstrate these to students and other members of her staff. The head nurse must show her expert nursing ability in the maintenance of quiet, providing privacy for her patients, and avoiding unnecessary stress and strain such as over-visiting by a well meaning friend.

She must be able to evaluate the nursing service in her unit as nurses of good judgment are able to recognize strengths and weaknesses in the service which are often overlooked by the ordinary observer.

The head nurse also plays the part of sanitarian in her department. In performing this duty, she must see that proper temperatures are maintained, that lighting facilities aer adequate, that plumbing is functioning properly, and that wastes such as surgical dressings are disposed of. A good prophylactic technique well carried out will control and prevent disease, whereas poor technique will endanger not only the patients but also the staff and community as well.

Included in her many duties the head nurse must be a housekeeper and a steward as well. Regardless of the organization of the housekeeping in the institution, she is responsible for the general cleanliness of her units and for the special care and upkeep of the furnishings and equipment. The equipment is costly but the intelligence with which it is selected and the way it is used, repaired, and cared for will determine to a large extent its length of wear and effectiveness of use. Moreover, if she shows intelligence in choosing and caring for what she has she is more likely to obtain the further equipment she requires to carry on her ward.

The head nurse must also be an economist. Waste in all its forms is preventable and constant effort should be made to eliminate it. The head nurse must bear this in mind continually and emphasize to her staff the importance of the conservation of materials, time, and energy. She should not make the mistake of thinking that she is able to do everything by herself but rather should stimulate the members of her staff to their greatest effort and direct the work so that each will be able to devote the maximum time and energy to the most essential functions.

One of the most important roles played by the head nurse is that of a teacher. Every good nurse recognizes the importance of good health, not only of the patients but also of the workers in the hospital and the members of the community generally. Every nurse should be prepared to function as a health teacher. Every patient should learn how to recover and then how to follow a suitable health program after discharge. This instruction is best given by the person giving nursing care but is more effective if it is a plan of health instruction first outlined by the head nurse.

In many schools of nursing the head nurse is also responsible for the clinical teaching of the students. She must be able to plan clinical experience so that they will receive adequate training in the basic essentials. She must be familiar with the classroom work as it is taught so that she will be able to correlate theory and practice. This means the development of a systematic plan of education to utilize to the fullest extent the educational opportunities which the hospital practice field provides. She should be skilled in the techniques of student guidance so that each student may develop professionally and emotionally.

Thus, we see that the head nurse must be a hostess, nurse, teacher, and administrator if she is able to perform her duties adequately and efficiently. As stated in the first part of this article, the major duties of the head nurse are to be a hostess, a manager of ward personnel, an economist, a sanitarian, a nursing expert, and a teacher.

Being a hostess constitutes the major part of her work and so I have

estimated that 24 hours of a 48-hour week should be devoted to this work—that is to say, that three hours and 20 minutes each day should be spent visiting patients, making rounds with doctors, and meeting visitors coming to the ward.

As manager of ward personnel, I have estimated 18 hours a week or three hours a day. This is time spent in assigning duties, supervising nursing procedures, and helping all members of her staff with their duties and problems.

I believe three hours a week should be devoted to the functions of economist and sanitarian. This is approximately one-half hour a day when she should inspect plumbing facilities, lighting, and ventilation and see that economy of time, energy, and supplies is being properly regarded by all members of her staff.

Being a nursing expert and a teacher are closely related and so I have combined these two and have allowed four hours a week or 35 minutes a day to this function. Although this does not seem like very much time to spend on this important aspect of her work, the head nurse is actually carrying out this duty while fulfilling all her various other duties.

In order to capably assume the position of a head nurse there are certain qualifications both personal and professional that the individual must be able to fulfil.

Personal qualifications include a deep understanding of people, maturity of thought and action, and high qualities of leadership. She must be able to gain confidence through reliability and sincerity and have a true loyalty to her own school and the institution where she is now working. She must have patience, tact, and a sense of humor; tolerance, initiative, perseverance, and courage for often she will meet what will seem to be overwhelming difficulties. The efficient head nurse must have self-reliance, enthusiasm, and resourcefulness, as well as considerable nervous and physical energy. She must rank well above her group in managing and teaching ability and in scholarship and such qualities as adaptability and cooperativeness which will produce good working conditions for an effective organization. She must also have an intelligent appreciation of her educational responsibilities and be able to direct learning activities among the students. Thus we see that she must be a growing person able to learn from her own experiences and stimulate growth in others.

As for her professional qualities she must be a graduate in good standing from a school whose standards meet the necessary requirements. She should be registered in the province and have at least one year of special preparation which should include a definite period of clinical instruction in addition to the study of ward management, teaching, and other problems which the head nurse must be qualified to handle. It is helpful if she has at least six months' experience in general nursing practice before beginning head nurse preparation. This may be in the form of general duty in a hospital, a visiting nurse, or as a private duty nurse. It is now becoming advisable for a head nurse to have added general education in a university, as well as the traditional high school education. This helps to broaden her outlook on life and makes her more capable of accepting the responsibilities she will be required to assume.

Thus we see that the position of a head nurse is not an easy one, which can be filled by any graduate nurse, but rather it is one requiring a well developed individual with added education and experience. It is not a position of great honor but is one which offers great possibilities of personal satisfaction, if the job is thoroughly and adequately performed.

I shall pass through this world but once. Any good thing that I can do, or any kindness that I can show to any human being, let me do it now. Let me not defer it or neglect it, for I shall not pass this way again—WM. PENN.

Public Health Nursing

One Year on Exchange

ROXINA BRANDON

IN THE SUMMER OF 1950 I exchanged the mufti of the Lambton Health Unit, Sarnia, Ont., for the uniform of the Queen's Institute of District Nursing, Coventry, England. The Q.I.D.N.S. is the mother of our Victorian Order of Nurses. Their uniform came complete with flashes, epaulettes, and a new set of nursing duties.

I crossed the Atlantic with two friends—exchange teachers—and I think the *Queen Mary* was quite unaware of the excitement and trepidation of her three obscure passengers.

We had so arranged our leave that before we went our separate ways we were to have six weeks' holiday together. Evening after evening of the previous winter we had planned and budgeted. What would we see? Where would we stay? How much would it cost? At last our plans were complete.

On July 13 we landed at Southampton and delved at once into the mysteries of "£.s.d." It wasn't sufficient to have to struggle with the money. We decided to go where we understood neither language or finance and so add to the confusion. Our first stop was Paris.

We had crossed the Atlantic with never a qualm so none of us feared the hour and a half over the channel. What a delusion! It remained the greatest fear of our travelling for me. There were times when I could view it with humor but never when we were planning another trip to the Continent.

The Université de Paris was our headquarters. For a few francs a night (about 75 cents) we were allotted one of the students' room in Maison Deutsch de la Meurthe. With Maison Canadienne close at hand in a setting of spacious lawns and carefully tended flowers, we felt quite at home.

For seven beautifully sunny days, Paris enthralled us. The Champs Elysées, the Eiffel Tower, the Louvre with the Mona Lisa—the Arc de Triomphe, Notre Dame, dinner at a sidewalk café—the shops, the National Theatre of the Opera—the bouquinistes along the Seine!

Seven days were not nearly enough but we had other fields to conquer. With a hunger to return to France at a later date, we battled once more with the French porters and hurried back to England.

At King's Cross Station we boarded the *Flying Scotsman* for Prince Charlie's country. Edinburgh became our home for a week. From here we saw Scott's country, Loch Lomond and the Trossachs; Traquair House, whose gates were closed when Bonnie Prince Charlie left and will only be opened again when another Charles is on the throne.

Thence to the highlands and Inverness. We picked the heather on the hills and looked for the "monster" of Loch Ness. We followed the Road to the Isles and went over the sea to Skye. The highland games at Strathpeffer were a never-to-be-forgotten sight. The lads and lassies in their kilts, dancing, piping and tossing the caber; the lord and lady of the manor being graciously hospitable.

Wales, too, we must see. Bettws-y-Coed, where we found the Fairy Glen and Swallow Falls, was beautiful despite the rain. Defying the weather with "macs and wellingtons," we walked the moors, climbed Snowden

Miss Brandon is a public health nurse with the Lambton Health Unit in Ontario.

and visited Carnarvon Castle where the first Prince of Wales was presented to the Welsh people.

But now it was August and once again I must work for a living. What would I be doing?—where would I be living? Would I have an ogre for a supervisor? The time had come to find out. When I stepped onto the platform at Coventry station, a warm reception awaited me. Miss H. B. Auckland, M.B.E., superintendent, Q.I.D.N.S., greeted me. In a few minutes we had reached 8 Park Road where I was to spend one of the happiest and most interesting years of my life.

One of the key training residences for Queen's Nurses in Britain, 8 Park Road, is home, training school, and office for some 20 to 30 staff nurses (exclusive of part-time and living-out staff), the superintendent and three assistants. One of the latter had exchanged with me and I tried inadequately to take her place.

The nurses' morning started at 7:40 when breakfast was served. Then they gathered in the office to receive their morning's work list. The telephone began ringing—doctors giving orders, outside staff wanting their lists of patients, and I trying frantically to understand the English accent which sounded like a foreign tongue to me over the telephone.

Some mornings I would make rounds with the candidates. Fortunately, the Queen's nursing technique is the same as ours in the V.O.N. In emergencies I would go out with a little black bag myself to bathe a patient, give an enema, a streptomycin injection or do a dressing. At other times my head was deep in record books and the numerous reports required by the National Health Service.

I was particularly fortunate in being sent to Miss Auckland. She arranged for me to attend the lectures with the Queen's candidates, spend some time observing school nursing in Plymouth, public health in Coventry, and Queen's nursing in Brighton and London and as many clinics and hospitals as were possible.

Christmas in England was a happy time. The hospitality of the Coventry home was extended to my friends who will never forget their first Christmas in residence. The traditional pillowcases, which are an adequate substitute for our stockings, were filled. The long tables were set in a festive manner and we indulged in a delicious turkey dinner with all the trimmings. Later we gathered about the open fire to receive small gifts and sing carols. We saw the incomparable Christmas pantomimes and attended midnight mass at Coventry's beautiful 12th-century St. John's Church.

Miss Auckland felt that the value of the exchange scheme did not lie wholly in the realm of nursing but that I must get to know England and the English people. My time was, therefore, arranged to best advantage and I spent week-ends absorbing the beauties of English countryside and enjoying to the full the friendliness and hospitality of the English people.

When finances permitted we would rent a disreputable old car and drive (occasionally on the proper side of the road!) down the beautiful Devon lanes or through the Wye Valley or perhaps among the Cotswold Hills, all the while trying to keep the driver propped up on a biscuit tin and praying that the rain would stay on the roof and not come through.

London! The changing of the guard—the opening of parliament—the trooping of the colors! The thrill of the Royal Garden Party with Her Majesty graciously receiving us! The ballet, the opera! Trafalgar Square and Piccadilly Circus! Taking the 8:25 from Waterloo! Is there enough time ever to steep in the atmosphere and gather to you all the wonders of such a city? We walked the Bloody Tower. We watched Mr. Churchill in the House of Commons. We saw Queen Mary shopping in Harrods. Saw the crowds gathered around Clarence House awaiting the birth of Princess Anne.

Did ever a year pass so quickly? It was Easter and we still had so much to do, so much to see. Comfort-

ed with the of efficiency "Quells," we once again headed for Dover and the Continent. This time Switzerland was our destination. Have you ever taken a bus from Interlaken to the Niederhorn with a group of young Swiss lads yodelling? Have you taken a chair-lift to the top of the mountain, being carried up and up with the grandeur of Switzerland being unfolded below?

From the Bernese Oberland we went southward to the Italian part of Switzerland—Lugano. So different but drawing us with its enchantment of lakes, arcades, funiculars, pottery and woodcarving.

We crossed the border into Italy and visited Milan, home of the famous "Last Supper." All too soon we bade good-bye to sunshine and food and set out for home—for England was now home to us.

Being Irish by descent I could not return happily to Canada without a glimpse of the Emerald Isle. Miss Auckland and I spent two unforgettable weeks there. In Dublin we went to the Gate Theatre and the famous Old Abbey Theatre which has since been burned. We stayed at Killarney and Tralee which have rightly made songs famous. We kissed the Blarney Stone and sailed in Dingle Bay. Instead of passing along quickly in a car or bus or train, as often as possible we adopted the easy, lazy Irish way of transport—the jaunting cart. In smaller towns such as Killarney, the streets were full of donkey-carts pulling their owners or loads of peat along. Killarney lakes and dells with emerald grass and bright yellow gorse hedges are truly a home for the angels to rest.

Once more I waited for a train at Coventry. With sincere regret I bade farewell to Lady Godiva's Coventry and the friends I had made. Not a last farewell for I will surely visit again this beautiful land praised through the ages by poets.

How About Your Will?

It is unfortunate that in the past the idea of making a will frequently has been associated with the impending death of the maker. As a result, this very important duty and quite interesting task often has been delayed until too late.

The time to make your will is *now*—when you are in good health and of sound mind. It is not a deathbed duty but an important precautionary step to be taken at once in the interests of yourself, your estate, and your dependents even though you are in the prime of life and at the height of your professional career. It is the only way by which you can definitely direct the disposal of your estate along the lines you believe would be best in the interests of your dependents. Once a will is properly drawn and completed it develops within the maker a feeling of satisfaction that her affairs are in good order.

There is no reason for delaying the making of a will which suits your present conditions because a will may be changed by codicil or completely rewritten at any time. The latest will, if properly drawn, entirely cancels all former wills.

In every will, the one who is to carry out its provisions should be named. The maker may select one or more relatives or individual friends, he may name a responsible, well-managed trust company to act alone, or he may name a trust company to act jointly with some member of his family or some business friend.

In the settlement of an estate there are numerous duties to be performed by the executors. They must make sure that the family has some ready money to carry on with, then pay all just debts, make succession duty returns, and negotiate with the various governments regarding amount of succession duties to be paid. They must adjust all income tax matters.

Because the settlement of even the average estate involves so many transactions, for the proper handling of which adequate powers as well as experience and familiarity with such matters are of vital importance, it is not only very advisable to make a careful choice of executors but they should be given broad and complete powers. Your executors

(*Continued on page 734*)

Aux Infirmières Canadiennes-Françaises

Lutte Contre le Glaucôme

SOEUR MARIE DE L'ASSOMPTION, R.H.

LE MOT glaucôme est très ancien et servait à désigner une couleur verdâtre ou bleuâtre de la pupille. Il est pourtant certain que la maladie, telle que nous la concevons actuellement, n'était pas connue des médecins de l'antiquité, pas même dans ses principaux symptômes extérieurs. Hippocrate confondait le glaucôme avec la cataracte.

Au dix-septième siècle, Brisseau ayant disséqué des yeux y constata, outre la cataracte, un léger trouble jaunâtre du corps vitré. Cet auteur conclut que le glaucôme était le résultat d'une maladie spéciale de l'épithélium choroidien. Après lui, vint le célèbre oculiste viennois, Joseph Beer, puis Desmarres, Weber, Greafe, pour ne nommer que les principaux, lesquels en arrivèrent à une connaissance assez parfaite des symptômes du glaucôme, tels que nous les connaissons aujourd'hui, mais nous n'étions alors qu'à la période préophtalmoscopique. Voici 1851 et la découverte de l'ophtalmoscope par Helmhaltz. Avec lui l'ophtalmologie entre dans une ère de progrès, car maintenant il sera possible de voir les milieux de l'oeil et de constater l'excavation papillaire. Enfin, 1876, Laqueur est le premier à employer le myotique utilisé jusqu'à nos jours—l'ésérine.

L'aspect social de la lutte contre le glaucôme n'a pas encore atteint l'ampleur comparable à celle déployée contre la tuberculose, la syphilis, et le cancer. Mais depuis quelques années, surtout depuis le congrès de Londres en juillet 1950 où les ophtalmologistes de tous les pays avaient pour sujet d'étude "La Classification des Causes de la Cécité," les résultats furent d'attirer l'attention générale sur la fréquence du glaucôme et ce dans tous les pays.

Au Canada, une personne sur 800 est atteinte de cécité; le glaucôme à lui seul est responsable de 15 pour cent de la totalité de ces cas de cécité.

Autrefois, on définissait de la tension intraoculaire; aujourd'hui, nous constatons qu'il y a des glaucômes sans tension oculaire, cependant la forme rencontrée le plus souvent dans la clinique est le glaucôme chronique ou le glaucôme tout court.

SYMPTOMATOLOGIE

Le glaucôme est une maladie à début insidieux, dont le diagnostic précoce nécessite des examens aussi nombreux que minutieux. Il intéresse un ou les deux yeux et il faut tenir compte des observations du patient qui vient consulter à la suite de brouillards passagers, anneaux aux couleurs de l'arc-en-ciel autour des lumières, d'une diminution de la vision ou de douleurs sous forme de migraine.

EVOLUTION

Le glaucôme évolue ordinairement vers la cécité et le malade non traité devient aveugle. S'il est traité, le résultat dépend de la maladie au moment de la consultation et de la fidélité dans l'application du traitement.

TRAITEMENT

Il est reconnu universellement que le glaucôme n'est pas une maladie de l'oeil en soi mais une manifestation locale d'un trouble général constitutionnel. L'oeil est un organe malade mais, comme partie d'un organisme malade, aussi à notre clinique nous aurons un médecin qui s'occupera activement de l'état général de chaque patient souffrant de glaucôme. Tous

Soeur Marie de l'Assomption est hospitalière à l'Hôtel-Dieu de Montréal.

les auteurs s'accordent à dire que le glaucômateux est irritable, émotif, anxieux. Il est donc nécessaire de diriger notre attention vers cet état et d'y chercher les facteurs responsables du déséquilibre. Tout oculiste, en observant des cas de ce genre, doit conseiller à ses clients prédisposés au glaucôme d'éviter les impressions.

Le traitement topique est nécessaire et consiste dans l'emploi de myotique, tels que pilocarpine, ésérine, etc. Aujourd'hui, nous avons à notre disposition, grâce aux produits du Laboratoire Merck, le floropryl qui est plus puissant que les deux autres topiques nommés mais ne peut être employé aussi couramment parce que moins connu dans ses résultats. Les médecins croient que ce médicament est appelé à rendre de grands services. Le malade, qui, pour maintenir la tension oculaire normale, a recours à la pilocarpine six fois par jour, appréciera de mettre floropryl une seule fois; l'aide nécessaire pour ces traitements lui manquant fréquemment. Enfin, si la tension se maintient malgré les myotiques employés, le médecin observant le champ visuel de son malade de temps en temps et constatant que ce champ se rétrécit dans la periphérie et que la tension reste augmentée, le traitement chirurgical s'imposera.

Le but de l'intervention n'est pas de redonner la vision mais de soulager le malade et de lui conserver ce qui lui en reste; donc nécessité d'intervenir à temps. L'opération consiste à créer une fistulisation sous-conjonctivale amenant une soupape de sûreté. Nous possédons depuis peu un appareil pour cyclo-électrolise beaucoup plus simple puisque ce n'est qu'un traitement dont le patient peut bénéficier comme malade externe. A date, nous n'avons que quelques malades traitées mais les résultats semblent bons.

Your Will

(*Concluded from page 732*)

will have no powers beyond those incorporated in your will. A will may be made by a person either in what is known as holograph form, or in the presence of witnesses, or in notarial form.

A Holograph Will must be entirely in the testator's own handwriting from first to last and requires no witnesses to the testator's signature. It should state clearly that it is the maker's last will; it should show the date upon which it is made and it must, of course, be signed. Find out about the legal standing of such a will in your own province before you draw it up.

A holograph will should be made only as a temporary provision or where the services of a qualified notary or lawyer cannot be obtained.

A holograph will requires to be probated.

A *Will before Witnesses*, commonly called *a Will in English Form*, need not be in the handwriting of the testator. It may be in the handwriting of another person or typewritten or printed but it must be signed by the testator in the presence of two witnesses and these witnesses must immediately, after the testator and at his request, sign the will in his presence and in the presence of one another.

Witnesses should be reasonably well known people who can be traced in later years. If a beneficiary under a will acts as witness the legacy is void. Women may serve as witnesses but a woman cannot be a witness with her husband in the province of Quebec. A minor cannot act as witness.

A will in English form requires to be probated.

Notarial Wills may be made in the presence of a notary and two witnesses or before two notaries. There are special conditions as to certain persons who cannot act as witnesses to a notarial will. Notarial wills, which in Canada are valid in the province of Quebec only, do not require to be probated.

— *Crown Trust Company*

Where you are is of no moment, but only what you are doing there. It is not the place that ennobles you but you the place: and this only by doing that which is great and noble.—*Selected.*

Trends in Nursing

Back to Work

Now that the "lazy days" of summer are but a happy memory, refreshed in mind and body from restful holidays, nurses will be turning their thoughts to various forms of winter activity. Soon we will all be caught up in the whirl of meetings, conferences, and so forth.

Many of the nurses who were privileged to attend the 26th biennial convention, C.N.A., last June are probably occupied with the preparation of reports of these meetings, while those who held the line on the home front are eagerly looking forward to hearing the details of all that happened during that memorable week. A great deal of information has already appeared in previous issues of the *Journal* and the following is only intended to fill in the gaps.

Structure Study, C.N.A.

Two full sessions were devoted to the Structure Study Report. Miss Florence Emory, chairman, with several members of her committee and Dr. Pauline Jewett, director of the Study, were on the platform at the first session to answer questions and participate in the discussion. Clarification and interpretation of the report were sought by several delegates and members. No decisions were taken at this time. The president of the C.N.A. explained that time would be allowed for further discussion and a decision as to the action to be taken in reference to this report on the final day of the meeting. Dr. Jewett was requested to again be available to answer questions and give further clarification of her report if so required.

The following motion was adopted on June 7, 1952:

> That all action on the Structure Study Report except study by the provincial nurses' associations and study at the 1952 biennial meeting be deferred until the Executive Committee meeting to be called in the autumn of 1953, and that action in regard to the recommended changes in the structure of the C.N.A. be taken at the biennial meeting in 1954.

Bursaries for Student Nurses

A request came from the Canadian Commission on Nursing that nursing associations endeavor to secure and arrange for the award of bursaries to suitable applicants for admission to schools of nursing, who might otherwise be prevented from enrolling because of limited finance. The general secretary forwarded this suggestion to the provincial associations and invited comment from those who had employed such methods. We are indebted to Miss Edith Fenton, Public Relations secretary of the Registered Nurses' Association of Ontario, for sending us information regarding bursaries given in District 5. This material was prepared by the chairman of the R.N.A.O. Bursary Committee, Miss Jennie E. Ives. The following are excerpts taken from this report:

> Early in 1948, the Board of Directors of the R.N.A.O. suggested to the District Executives that a project be undertaken to secure and award bursaries to suitable students for schools of nursing. This was intended to assist applicants who were prevented from entering a nursing school due to lack of finance.
>
> *Purpose:*
>
> 1. To increase the registration of students.
> 2. To increase the nursing service in the community.
> 3. To make the public more conscious of nursing needs.
>
> District 5 accepted this challenge and formed a small committee which first met on May 31, 1948. As they had no pattern, this meeting was largely an organizing group which entered actively into discussion of salient points. The educational committee of the R.N.A.O. had suggested the amount of a bursary should be $300—i.e., $100 per year. This

seemed a small amount, so the members decided to investigate and to find out from various schools the approximate cost experienced by the students.

In order to make the public more conscious of nursing needs it was felt the source of money might be from non-professional groups such as service clubs. Having made some progress by deciding the approximate amount of a bursary and the suggested source, the next problem was where to find applicants. It was decided the principals of schools could be approached to secure names of interested students and to invite applications; also the public health nurses in the districts might direct worthy applicants. Later, this problem solved itself as the superintendents of nurses co-operated and the information is now in the prospectus of each school of nursing.

As a guide, the following qualifications for an applicant were set down:

(1) Young, interested student; (2) minimum academic qualification; (3) maximum personal qualification; (4) sincere desire to enter the profession; (5) physical fitness.

The first request for assistance was received in November, 1948. The committee actively sought financial assistance from service clubs and in January, 1949, the first bursary was allocated. Enthusiasm grew and, as publicity spread, more applications were received, thus requiring more activity on the part of the committee. Policies were drawn up and followed during 1949-50. These were revised in May, 1951, and May, 1952.

The committee has made every effort to publicize the fact that financial assistance is often necessary if student recruitment is to be increased. Realizing the need for more nurses, several service clubs, organizations, and interested individuals have contributed financially to the Bursary Funds. In June, 1951, District 5 sponsored a concert to raise funds for educational purposes. Of the proceeds, $500 has been made available to the committee to date. The yearly outlay for bursaries is as follows:

In 1949.....	$ 600
In 1950.....	900
In 1951.....	2,687
	$4,187

The committee has received, studied, and carefully dealt with 37 applications to date. Of this number, 4 withdrew their request; 6 were rejected; 12 have received partial assistance—$50-$300; 10 have received full assistance—$400; 5 remain to be discussed.

In order to strengthen the activities of the committee, a representative from each school is now a member.

Policies governing bursaries have been carefully prepared and further information concerning these may be obtained from National Office, C.N.A. We salute the enterprising chairman of District 5, R.N.A.O., and her committee for initiating such a worthy project. Let us hear more about such recruitment ventures from others.

Recruitment—A Social Problem

This is the theme of an interesting investigation recently carried out by Miss Mary Farnworth, B.Sc., of London, Eng. The main part of her study appears in the June 21 and subsequent issues of *Nursing Times:*

The community must accept responsibility for the care of its sick members. This is recognized today and particularly in this country with its National Health Service. But how far is the community responsible for seeing that there are sufficient skilled and trained people to ensure that the best service is in fact available to those who need it?

The shortage of nurses is blamed for the long waiting lists of patients, while there are empty beds in hospitals. The causes of the shortage have been sought and a multiplicity of recommendations made. This very multiplicity would suggest that the fundamental factors have not been found for in medicine, where there are many theories of causation and many remedies advocated, it often means that the exact cause and the specific treatment are still unknown. On the other hand it may mean there is no single or basic reason but so many that only some have been resolved in each case.

At one end of the shortage problem is the question of recruitment and so long as there are nursing schools with vacancies for students or pupils it indicates that recruitment is not at its maximum.

It is an essential of any modern investigation, on whatever subject, that an analysis of the whole situation is made before remedies are advocated. Indeed, even when an analysis has been made, it may not be the task of the investigators to propose remedies but rather that of people most concerned or responsible who, having studied the analysis provided, can see how best to achieve further progress.

Nursing recruitment has for years been a thorny problem and one on which almost anyone is ready to propose remedies—even those of "catching them young" and "paying them better." It is a step forward, therefore, to find that a research worker, herself a nurse, has undertaken an investigation into what she describes as one part of the complex problem of recruitment—the social prestige of nursing.

Miss Farnworth was concerned with the nursing recruitment situation as a problem of social psychology. It concerns all nurses who must accept responsibility for the further growth and development of their profession. For the smaller group who are interested in the method of investigation and further details the complete document can be studied at the Royal College of Nursing Library.

The first point Miss Farnworth makes is the contrast in the prestige of nursing immediately before and shortly after the founding of the Nightingale Training School at St. Thomas' Hospital in 1860. The careful selection of the candidates was, evidently, one of the salient factors in creating this sharp line of demarcation between the nurse described by Dickens and the nurses who came after Miss Nightingale. There can be no doubt that there was a great need for nurses in those early years of the profession but Miss Nightingale was adamant in demanding and maintaining a high standard rather than saying, as many do now, "the need is so great we cannot afford to be selective."

Another factor is that the work undertaken should be selected so that the skill and training acquired in a long preparation is not wasted on unskilled tasks. The employment of nurses on any practical duty that needs doing in a hospital or clinic cannot be called an economy when nursing treatment is being delayed for lack of trained staff. Many special centres in particular, such as those for spinal injuries, thoracic surgery, premature infants, or psychiatric treatment, need specialist nurses. Perhaps it will be through these that the particular skill of the nurse will come to be recognized within the medical and nursing world.

But what of the opinion of the general public of the nurse's work? Arising from this social study it is evident that parents have very decided views on nursing. Their opinions are hard to change but their cooperation must be gained. They are entitled to seek acceptable conditions, reasonable freedom, and adequate care of the health of their daughters, while expecting that teaching and experience should be given at a standard that will be recognized as of value in themselves and as a fitting preparation for promotion later. For those girls who seek only the immediate well-paid job with regular hours as a temporary occupation before marriage, nursing cannot compete. Those parents who take a longer view, however, could be given much help by talks by informed members of the profession. Rather than relying on cadet schemes to "bridge the gap" the nursing profession should also be made more attractive to women who have already some experience of the community and its social problems and who have found other work lacking in the satisfaction nursing can give.

Miss Farnworth suggests that the attitude to nursing depends rather on the cultural background and on the "values" accepted than on the social level. Nursing is a service and, as such, appeals rather to those whose background has taught them that service to the community is of the highest not the lowest value. Recognition by the community of the value of that service in ways which are understood by the public—such as salaries and posts of responsibility within the community—must also be given. The position of nursing in other countries is worth considering in this respect so that the relative status of nursing can be considered with this problem in mind.

Are we then approaching the recruitment problem from the best angle in appealing mainly to the young person with

an undirected desire to serve but with little knowledge of the community? Should not nursing be more closely recognized as one part of the social services, requiring special preparation and carrying special responsibilities, but with a comparable prestige in matters of public recognition?

More About Research in Nursing

A most attractive bulletin entitled *Nursing Research*, Vol. 1, No. 1, appeared on our desk recently. Published by *The American Journal of Nursing*, it was created to serve two purposes: To inform members of the nursing profession and allies professions of the results of scientific studies in nursing; and to stimulate research in nursing. Among the articles contained in this bulletin we were particularly interested in an abstract of a dissertation by Margery J. Mack entitled "The Personal Adjustment of Chronically Ill, Old People Under Home Care."

It is our understanding that this is but the beginning of a series of bulletins on nursing research to be published by *The American Journal of Nursing*.

I.C.N. News Letter

The Fifth World Health Assembly opened at the Palais des Nations in Geneva on May 5, 1952, and delegates attended from 67 countries, (64 full members and 3 associate members). In addition, two non-member countries sent observers. Observers were also present from the United Nations and most of its specialized agencies, as well as from non-governmental organizations working in the field of international health. The I.C.N. (being a non-governmental organization in official relationship with WHO) was represented during the first week by Madame Germaine Vernet, president of the Swiss Association of Graduate Nurses, and by the executive secretary during the remainder of the Assembly. Miss Ruth Taylor (director of Nursing Division of the Children's Bureau in Washington) attended as nursing adviser with the U.S.A. delegation; and Miss Astrid Janzon (director of the State School of Nursing in Stockholm) attended as nursing adviser with the Swedish delegation. The Burmese delegation was lead by Mrs. Aung San, a nurse and midwife who is director under the Department of Health, of the Maternal and Child Welfare Services in Burma.

At an early Plenary Session, Dr. Juan Salcedo, Minister of Health for the Philippines Republic, was elected president in succession to Dr. Leonard Scheele, who has held office during the past year.

One new country, the United Kingdom of Libya, was admitted into full membership; Morocco and Tunisia obtained associate status.

In all the opening speeches, attention was drawn to the progress made by the Organization during the past year. "Regionalization" is now complete, with Regional Committees in six areas. Health demonstrations and disease campaigns have lead to greater reductions in sickness rates. Malaria, venereal diseases, yellow fever, and other menacing diseases are being brought under control. Tuberculosis and diseases due to lack of environmental sanitation are receding and new discoveries are leading towards the control of leprosy and the prevention of poliomyelitis.

During the first two weeks, the Assembly discussed in its main committees the working of the Organization, with particular reference to the report of the Director-General for 1951 and the proposed program and budget for 1953. Delegates and observers were able to participate freely, speaking as individuals and technicians and not as delegates of any country or organization. Under the general theme, the following aspects of the subject were discussed:

The necessity and methods for the making of surveys prior to the setting up or developing of a local health service; the function and scope of the service; the types of health workers needed (including voluntary workers); committee participation; the provision of health centres. It was agreed that the minimum provision of staff at such centres must

include a *medical officer*, responsible for medical care, the prevention of communicable diseases, and general policies; a *public health nurse* and *midwife*, responsible for maternal and child welfare; and *technicians*, responsible for sanitation problems, water supplies, and immunization and vaccination programs.

Certain important decisions were taken in the course of the Assembly which will have repercussions on the work of the Organization during the next period. Priority is to be given to the less developed countries when fellows are selected for individual studies abroad. Expert Committees are to meet on poliomyelitis and rheumatism. WHO is to take joint action with UNICEF and other specialized agencies of the United Nations on long-range activities for children and the rehabilitation of the physically handicapped.

Conclusions of importance to the nursing profession: In the report of the Director-General, reference is constantly made to the essential part that nurses are playing and must continue to play, in the implementation of the work of WHO. The Nursing Section has already been instrumental in recruiting and placing more than 100 nurses in the field where WHO projects are being planned. The health departments of official governments are constantly seeking the help of the Nursing Section in establishing a good "pattern" in the administration of nursing services in their respective countries. Frequently, during the technical discussions, the public health nurse was referred to as a "key person" in any health service. It would, therefore, seem clearly necessary that nurses should be present and their views heard when these matters are discussed. Once again, national associations are urged to bring pressure to bear on the health departments of their governments, so that a nurse adviser may be included in all the official delegations to future World Health Assemblies.

Orientation et Tendances en Nursing

De Retour au Travail

Déjà les vacances s'achèvent et pour un grand nombre ce n'est déjà plus qu'un heureux souvenir. Reposées de corps et d'esprit, les infirmières dirigent leur pensée vers les activités de l'hiver. Bientôt elles seront prises dans l'engrenage des assemblées, des conférences, etc.

Parmi les infirmières qui ont eu l'avantage d'assister au 26ième congrès de l'Association des Infirmières Canadiennes, en juin dernier, quelques-unes sont probablement occupées à rédiger un rapport des assemblées. Celles qui sont demeurées à la tâche anticipent le plaisir d'entendre les détails de cette semaine mémorable.

Déjà de nombreux articles sur le congrès ont paru dans la revue. Ce qui suit a pour but de compléter les informations données.

Étude de la Structure de l'A.I.C.

Deux sessions entières furent consacrées au rapport de l'Étude de la Structure de l'A.I.C. présenté par Mlle Florence Emory, convocatrice. Plusieurs membres du comité et le Dr Pauline Jewett, auteur du rapport, répondirent aux questions posées par l'assemblée. Après une discussion assez animée, la motion suivante fut adoptée le 7 juin 1952:

"Que toute action concernant le rapport de la Structure de l'A.I.C., sauf l'étude de ce rapport par les associations provinciales et l'étude faite au congrès biennal de 1952, soit remise jusqu'à la prochaine réunion du Comité Exécutif à l'automne de 1953 et que toute action concernant les changements recommandés dans le rapport de la Structure de l'A.I.C. soit remise au prochain congrès biennal de 1954."

Bourses d'Étude pour les Étudiantes Infirmières

La Commission Canadienne du Nursing demanda aux associations provinciales de

prendre les mesures et de faire les arrangements nécessaires pour obtenir des bourses d'études aux candidates infirmières, dont un certain nombre, sans cette aide, ne pourraient entreprendre des études d'infirmières. La secrétaire nationale demanda aux associations provinciales ce qu'elles avaient fait dans ce sens. L'expérience tentée par l'Association des Infirmières Enregistrées de l'Ontario mérite d'être mentionnée. S'adressant aux comités de régies des divers districts, l'A.I.E.O. demanda de venir en aide aux candidates infirmières qui ne peuvent entrer dans une école d'infirmières, faute de ressources financières.

Tout projet devait avoir pour buts:

1. D'augmenter le recrutement d'étudiantes infirmières.
2. D'augmenter les soins infirmiers offerts au public.
3. Renseigner le public sur le besoin et la valeur du nursing.

Le District 5 décida de tenter un effort dans ce sens et un petit comité fut formé en mai, 1948. Un montant de $300 fut suggéré comme bourse d'étude par l'A.I.E.O. ($100 par année).

Afin de rendre le public conscient de la valeur du nursing au point de vue social, il fut décidé de faire appel aux groupements non-professionnels tels qu'organisations sociales. Ayant décidé du montant de la bourse et de la source des revenus, il ne restait qu'à trouver des candidates. La coopération des directrices des écoles rendit cette dernière partie du travail facile.

Comme guide dans le choix des candidates, les qualifications suivantes furent déterminées:

1. Étudiante jeune et intéressée.
2. Degré minimum d'instruction requise.
3. Maximum de qualités personnelles.
4. Désir sincère de devenir infirmière.
5. Bonne santé.

La première bourse d'étude fut accordée en janvier, 1949. La publicité faite lors de l'octroi de cette bourse augmenta l'enthousiasme et plusieurs demandes furent reçues.

Le comité a tenté par tous les efforts possibles de publier le fait qu'une aide financière est souvent nécessaire pour augmenter le recrutement. Plusieurs organisations sociales, clubs et des particuliers, réalisant le besoin d'augmenter le nombre des infirmières, ont contribué au Fonds des Bourses. En juin, 1951, le District 5 organisa un concert et déposa $500 de profit dans la caisse.

Le montant des bourses accordées fut:

En 1949	$ 600
En 1950	900
En 1951	2,687
	$4,187

Le comité a reçu et étudié 37 demandes de bourses. De ce nombre—4 retirèrent leur demande; 6 furent rejetées; 12 reçurent une assistance financière variant de $50 à $300; 10 reçurent des bourses entières ($400); 5 sont encore à l'étude.

Le comité est formé d'une représentante de chaque école.

La politique établie concernant le Fonds des Bourses a été préparée avec soin et pour plus de renseignements les personnes intéressées peuvent s'adresser au Secrétariat National, A.I.C.

Recrutement—Un Problème Social

C'était le thème d'une intéressante étude faite récemment par Mlle Mary Farnworth, B.Sc., de Londres, Angleterre. Le résultat de cette étude apparaît en partie dans le *Nursing Times* du 21 juin, 1952, et la publication en sera continuée dans les numéros suivants:

"Assurer le soin des malades est une des responsabilités de la société—c'est un principe reconnu de nos jours, tout particulièrement dans les pays où il y a un service de santé subventionné par l'état. Mais jusqu'où va la responsabilité de la société? Dans le recrutement du personnel infirmier doit-elle voir à ce qu'il y ait suffisamment de personnel qualifié pour assurer à ceux qui en ont besoin la meilleure qualité de soins?

"Depuis longtemps l'on donne comme raison pour refuser les malades qui demandent leur admission aux hôpitaux—le manque d'infirmières. Les causes du manque d'infirmières ont été étudiées et bien des recommandations ont été faites à ce sujet. Comme dans les maladies bien des traitements sont appliqués, avant que la cause exacte et le traitement spécifique en soient trouvés.

"Chose certaine le meilleur moyen de mettre fin au manque d'infirmières est d'assurer le recrutement des étudiantes. La recrutement des candidates infirmières est un problème de psychologie sociale.

"Le prestige des infirmières de nos jours est moindre que celui accordé aux infirmières après la fondation de l'école d'infirmières du St. Thomas's Hospital. Il n'y a aucun doute qu'il y avait alors une grande demande d'in-

firmières, comme de nos jours; néanmoins, Mlle Nightingale était inflexible dans le choix des candidates et demandait que les normes de la profession soient élevées. Elle ne disait pas comme beaucoup trop de gens de nos jours—les besoins sont trop grands pour que nous soyons difficile sur le choix des candidates.

"Un facteur important à considérer dans le manque d'infirmières est le travail confié aux infirmières. Le travail et l'habileté de l'infirmière devraient être appliqués à des tâches pour lesquelles elle a été préparée. Les employeurs des infirmières devraient considérer qu'ils ne font pas d'économie lorsque les traitements sont retardés à cause d'un manque de personnel qualifié. L'hôpital et les malades ont tout à gagner lorsque des infirmières qualifiées—expérimentées—spécialisées—peuvent donner des soins en neurologie, en chirurgie thoracique, et aux prématurés. C'est peut-être l'habileté de l'infirmière dans ces divers domaines qu'ils la feront reconnaître par la profession médicale et par les infirmieres.

"Mlle Farnworth suggère d'insister sur la valeur sociale du nursing, plutôt que sur les avantages matériels sans toutefois oublier que les étudiantes ont droit à une certaine liberté, à de bonnes conditions de santé et de travail et, une fois diplômée, à de bons salaires. La reconnaissance par le public de la valeur sociale de la profession est du prestige qui lui est due ne doit pas être oubliés."

La Recherche en Nursing

Un élégant bulletin, intitulé *Nursing Research* (Vol. 1, No. 1) vient d'être publié par l'*American Journal of Nursing*. L'article suivant a attiré notre attention—"The Personal Adjustment of Chronically Ill Old People Under Home Care."

Conseil International des Infirmières

La Cinquième Assemblée de l'Organisation Mondiale de la Santé a eu lieu à Genève. Le C.I.I. fut representé par Mme Germaine Vernet, présidente de l'Association des Infirmières de Suisse, durant la première semaine et par la suite par la secrétaire.

Les centres de démonstrations et les campagnes de lutte contre les maladies ont donné de bons résultats. Le taux de la maladie est moins élevé. La malaria, les maladies vénériennes, la fièvre jaune et d'autres maladies sont maintenant maîtrisées. La tuberculose et les maladies résultant d'un manque d'hygiène ont également diminuées et de nouvelles découvertes nous conduiront à la guérison de la lèpre et la prévention de la poliomyélite.

Tous les délégués et les observateurs prirent librement part à la discussion, non comme délégué d'un pays ou d'une organisation mais individuellement à titre de technicien.

Les points suivants furent discutés: La nécessité et la méthode de faire une enquête avant d'établir ou de développer un service sanitaire régional; les catégories de personnel hygiéniste nécessaires (comprenant les aides bénévoles); la formation de comités; les dispositions à prendre dans l'organisation d'un service sanitaire. Il fut reconnu que le personnel minimum d'un centre sanitaire devrait se composer *d'un officier médical*, responsable des soins à donner, de la prévention des maladies contagieuses, et de la politique générale adoptée; d'*une infirmière hygiéniste et sage-femme*, responsable du bien-être maternel et de l'enfance; de *techniciens*, responsables de la sanitation (eau, immunisation et vaccination).

Des décisions importantes ont été prises et le travail de l'O.M.S. devra à l'avenir porter spécialement sur la formation de boursiers choisis de préférence dans les pays peu développés; sur l'étude de la poliomyélite et du rhumatisme; sur l'enfance et la réhabilitation des minorés physiques.

Importance de la profession d'infirmière: Dans le rapport du Directeur-Général de l'O.M.S. l'on rappelle constamment le rôle essentiel des infirmières dans le travail actuel et futur de l'Organisation et déjà plus de 100 infirmières ont été placées dans des endroits où l'O.M.S. se propose de réaliser des projets. Les services de santé des gouvernements demandent constamment l'aide de Comité du Nursing pour établir dans leur pays respectif un modèle dans l'administration des services du nursing.

Fréquemment, lors des discussions sur des problèmes techniques, l'infirmière hygiéniste est considérée comme la clef de voûte de l'organisation sanitaire. Il semble donc, à la suite de ces constatations, que les infirmières peuvent jouer chez nous le même rôle qu'elles jouent à l'étranger lorsque des questions de santé et de bien-être sont à l'étude. Une fois de plus les associations nationales d'infirmières sont priées de faire pression auprès des ministères de santé de leurs gouvernements pour qu'une infirmière soit déléguée à titre d'expert-conseil à toutes les assemblées futures de l'O.M.S.

Annual Meeting in Saskatchewan

The Saskatchewan Registered Nurses' Association held its 35th annual convention in the Bessborough Hotel in Saskatoon on May 15 and 16, 1952. Miss Isabelle Langstaff, president, presided at all sessions. Co-hostesses were the Northern Chapters of the S.R.N.A. at Humboldt, North Battleford, Prince Albert, Saskatoon, and Tisdale. Registration passed the 200 mark this year. The increased registration and the active participation by members in the various sessions marked a real gain in association interest.

The opening ceremonies included the invocation by the Rev. Martin Foley of the Catholic Hospital Conference of Saskatchewan and a welcome to Saskatoon on behalf of the City Council given by Alderman John Cairns, representing Mayor J. S. Mills.

In her presidential address, Miss Langstaff dealt with the affairs of the association as related to the individual members, the Council, and the staff of provincial office. She set forth the responsibilities of each and how, through cooperative efforts, we can strengthen and develop the work of our organization. In conclusion, Miss Langstaff said, "Remembering that we are a professional group with responsibilities, duties, aims, goals and privileges, not just a social club, we must continue to be informed to carefully guard the standards of our profession. It is usually the individual, not the association, that brings credit or discredit to nursing."

The secretary-registrar reported on the general activities for the year 1951-52. She noted the part the association had played in the work of the Health Survey Committee and mentioned the recent release of Volume I of the report of the committee, with Volume II to come at an early date.

Funds from the Dominion-Provincial Training Grant have made possible seven bursaries for nurses to undertake post-graduate study in public health nursing at Canadian universities. Two other nurses were awarded bursaries by the provincial government for graduate study in teaching and supervision.

The extension of the affiliation in psychiatric nursing for nursing students from two to three months; the participation of the professional staff of provincial office in the vocational guidance programs in the high schools in the province; the two hospital institutes for board members, administrators, and departmental heads conducted under the joint sponsorship of the Saskatchewan Hospital Association, the Division of Hospital Administration and Standards of the provincial Department of Public Health, and the S.R.N.A. held in November and December, 1951; the participation of the Moose Jaw General Hospital School of Nursing in the program of evaluation of the Metropolitan Demonstration School of Nursing at Windsor, Ont.; the institute on "The Setting and Marking of Examinations" generously sponsored by the University of Saskatchewan for members of the Board of Examiners for Nurse Registration in February, 1952; the Civil Defence training program for nurses and representation provided by our association on boards and committees of various official and non-official agencies, were among the items discussed in the report of the secretary-registrar.

Other reports from provincial office, various committees and chapters reflected the broad scope of the work undertaken during this past year by the S.R.N.A.

The intensely interesting and vital address on "Cobalt 60," given by Dr. H. E. Johns, associate professor of physics and physicist to the Saskatchewan Cancer Commission, during the last hour of the first morning's meeting was a highlight of the convention.

Chapter delegates gathered for an informal luncheon on the first day during which problems of special interest to the chapters were discussed.

The afternoon session on May 15 began with a panel discussion on "The Structure Study of the C.N.A." under the able chairmanship of Miss Elizabeth Smith. Members of the panel included Miss Ethel James, Sr. A. Levasseur, and Miss Patricia McGrath, all of Regina. General discussion followed from the floor. Points of agreement and disagreement on sections of the study brought out in the discussion were summarized to provide guidance for Saskatchewan delegates at the biennial meeting of the C.N.A. in the discussions on the Structure Study.

The remaining portion of the first afternoon session was devoted to discussion of the "Proposed Policies of the C.N.A." to be dealt with at the biennial meeting and voting

delegates were instructed at this time on the support of the S.R.N.A.

A delightful coffee party was held during the evening of May 15 in the Terrace Lounge of the Bessborough Hotel with the Northern Chapters acting as co-hostesses.

The committees on Institutional, Private, and Public Health Nursing met on Friday morning, May 16. The Institutional Committee heard summarized reports prepared by the chapters on the studies suggested by the Institutional Nursing Committee of the C.N.A. on "The Status of the General Staff Nurse in Regard to Education, Orientation, Service, Promotion, etc." and "The Nursing Team." Much active discussion resulted, particularly in relation to the latter report. The second half of the meeting provided for discussion and recommendations on personnel policies and salary schedules for nurses. The entire morning of the Public Health Nursing Committee was devoted to a panel presentation on "Prenatal Care" in which a number of guest speakers participated. The Private Nursing Committee dealt with a number of the problems relating to the conduct of private nursing registries.

Miss Edith Shepperd chaired a special meeting for nursing student delegates. For the first half of this period, Mr. James S. Wood, librarian of the Saskatoon Public Library, spoke on "Reading in General for Pleasure and Profit." The second half of the session was presented by the Beauty Counselors of Canada Ltd. on "Sensible Skin Care and Make-up Cosmetics."

The last hour of the morning's general session was devoted to a demonstration and discussion on "Improvised Equipment" directed by Miss Mary T. Mackenzie, St. Paul's Hospital, Saskatoon.

On the last afternoon another highlight of the annual meeting came when Dr. F. B. Roth, Deputy Minister of Health, gave an excellent address on "The Saskatchewan Health Survey Report." Following a brief introduction to the report in general, he presented to the delegates a brief overview of the nursing survey which will challenge all those present to study very carefully the material prepared in the Health Survey Report in respect to nursing in their province.

A ballot sent to all members prior to the annual meeting resulted in the following officers being elected to the S.R.N.A. Council for the term 1952-53:

Miss Dorothy Code, president; Miss Grace Motta, first vice-president; Rev. Sr. A. Ste. Croix, second vice-president; Miss Matilda Diederichs, councillor. Committee chairmen: Private Nursing, Miss Elizabeth Waddington (Saskatoon); Institutional Nursing, Miss Mary T. Mackenzie (Saskatoon); Public Health Nursing, Miss Louise Miner (Prince Albert).

LOLA WILSON
Secretary-Treasurer and Registrar

Attention — Manitoba Nurses!

Pilot Study on Inventory of Graduate Nurses in Canada

PERSONS CONCERNED WITH estimating the number of graduate nurses required to meet Civil Defence needs are almost invariably faced with deficits when available nurses are balanced against those required. This is a disturbing thought to conscientious planners. But we believe it can be remedied.

At the Regional Conferences of Health Services representatives held recently in Kingston, Halifax, and Regina, the matter of establishing an inventory of Graduate Nurses in Canada was discussed. In each region a small sub-committee, comprised of the Provincial Directors of Health Services and nurse representatives, Dr. L. O. Bradley, Executive Secretary of the Canadian Hospital Council; Dr. K. C. Charron, Chief, Health Planning Group; and Miss E. A. Pepper, Nursing Consultant, Health Planning Group, studied the problem from two major aspects: First, as an integral part of Health Services program at provincial and local levels; and, second, as a means of assisting in

alleviating the present obvious deficit of graduate nurses required to meet extended nursing services necessary in the event of a national emergency.

It was generally agreed that a concerted effort should be made to locate and maintain a record of retired, married, and inactive nurses in each province to supplement the existing record of active nurses presently maintained by the Registered Nurses' Association in their respective provinces.

Each sub-committee, after considering the problem involved, recommended that a "pilot study" be conducted in one province. In this way the best possible techniques could be worked out, errors corrected, and the cost of compiling and maintaining such an inventory assessed. During the discussions the Civil Defence authorities consulted with representatives of the personnel resources committee of the Defence Medical and Dental Services Advisory Board to ensure that information of value to the armed services and others would be included in the study.

Plans are now being formulated to initiate this "pilot study" in the province of Manitoba this fall. The provincial Civil Defence Health Services authorities, the Nursing Advisory Committee, and the Manitoba Association of Registered Nurses are working closely with the Canadian Nurses' Association, the Research Division of the Department of National Health and Welfare, the Civil Defence Health Planning Group and the Advisory Nursing Committee to the Health Planning Group on the details of the project. The dates on which the inventory will be taken will be announced in the October issue of *The Canadian Nurse.*

We are indebted to the Manitoba Civil Defence Health Services Committee, the Nursing Advisory Committee, and the Manitoba Association of Registered Nurses for their co-operation in this important phase of Civil Defence planning. On their behalf we would appeal to all graduate nurses in the province—active or inactive—to register.

Whether or not this project will be extended to all provinces in Canada will depend on good pre-registration planning and organization and the nurses themselves. May we count on *YOU?*

Yours sincerely,

G. D. W. CAMERON, M.D., D.P.H.
Deputy Minister of National Health.

Treatment of Motion Sickness

The exact mechanism by which protection against motion sickness is achieved is not known and no completely satisfactory drug is now available. However, compounds with pharmacologic properties similar to known effective agents should be considered and tested for possible efficacy.

Although certain antihistaminic drugs exert considerable protection, prophylaxis against motion sickness does not depend upon the antihistaminic action of the drug. Dramamime, Benadryl, and Perazil are quite effective against motion sickness whereas other antihistaminics, such as Neoantergan and Thephorin, are ineffective in doses eliciting strong antihistaminic action. The anticholinergic action seems the most plausible since other drugs with central atropine-like action, such as scopolamine hydrolinomide and artane, possess similar properties.

A summary of a report at a recent conference on motion sickness, sponsored by the U.S. Office of Naval Research, gave the following results:

1. No preparation was significantly superior to that of Benadryl although the per cent protection observed of Lergigan was somewhat greater.

2. Side-effects (nightmares, dry mouth, blurred vision, and ringing in the ears) were minimal in all cases except those persons receiving scopolamine aminoxide.

3. The highest incidence of vomiting was recorded for the age group 17-20 years and the lowest for the age group 30-39 years.

—*Am. J. Med.* 12: 433, 1952.

A Crying Need

ENID TRASK

IN YARMOUTH we have one of the finest consolidated high schools in the Maritimes which was opened in November, 1950; also a new vocational school which was opened in September, 1950. The latter is, in fact, one of the two vocational schools operating in Nova Scotia. It has an excellent teaching staff with good working equipment.

Fine! These schools will turn out a group of highly skilled young people for the professions, for businesses, and for the trades; but the most important group they should turn out as highly skilled girls is not even considered by these schools or by their curriculum. I refer to the group who ordinarily leave school in grades seven or eight from whom could be drawn the maids and housekeepers for homes, hospitals, and other institutions. This group of girls is utterly neglected in the vocational school planning.

Could not a small department be arranged in vocational schools all over Canada that would take over the basic and advanced training of these girls? Courses could be given, instructing them in routine household tasks, in the use and care of polishes, cleansers, detergents, utensils, and household appliances such as are used in an ordinary home. A few weeks could be devoted to lessons in courtesy, proper behavior, personal appearance, and personal hygiene. Those who wish an advanced course could be given classes in the plain cooking of vegetables, meats, soups, and simple desserts. (A maid I had at home, aged 22 years, did not know how to make jelly, and boiled potatoes for two hours!)

Courses still more advanced could be given in the duties of a housekeeper in a home, hotel or institution. These could include ordering groceries and meal-planning to utilize "left-overs" in an appetizing form.

If, at the end of the course, these girls could be given a standard uniform or badge, a certificate showing their degree of knowledge and ability, and if a standard wage were scheduled it might be an inducement for girls to take up this form of work. There might then be fewer "square pegs in round holes" for many of our so-called stenographers and commercial girls are unfit for office work.

When we remember the appearance of a squad of raw recruits in the army or a group of preliminary students in a school for nurses and, later, see the finished product as full-fledged soldiers or graduate nurses, we know how much can be done by training, despite what may seem to be somewhat unpromising material.

Could we not, all over Canada, as nurses' associations, recommend to our educational boards the desperate need of stable domestic help with which to keep our hospitals running smoothly? Could we not urge them to include such a course in their vocational schools?

We should stress the helplessness of a superintendent of nurses of a hospital when faced with the walk-out of two or three or more maids from a staff of nine while there are ill, helpless patients needing their food prepared, utensils cleansed, floors and rooms dusted, and laundry coming regularly and smoothly to each bed daily. If these young girls could be made to see the worthiness of work well done in a home or hospital, and could be given a certain standing, they would have pride in their work and thus toil with a better will and with becoming dignity.

Mrs. Trask has had much experience with the problems of hospital housekeeping at the Yarmouth (N.S.) Hospital where she is superintendent.

Knowledge is proud that he has learned so much; wisdom is humble that he knows no more.
—COWPER.

Student Nurses

Carcinomatosis

MAEJANET MACDONELL

CANCER IN A specific organ of the body is, unfortunately, all too common an occurrence. But cancer that is characterized by widespread dissemination throughout the body, affecting many different organs and tissues, was new to me until I met Mrs. Andrews.

A Scottish Canadian, Mrs. Andrews at 66 appears to have enjoyed reasonably good health until fairly recently. Though her husband is a bed-ridden invalid, her five sons are able to support their parents in comfort if not in luxury. There was, therefore, no financial problem nagging at Mrs. Andrews' mind as she was admitted to hospital on February 27.

Occasional twinges of what was called arthritis—pains in her back and hips—had bothered Mrs. Andrews for five years or more. Occasional periods of hospitalization had been ordered when the discomfort was most acute. Shortly after Christmas there was pain of an increased severity that radiated throughout the skull, spine, upper and lower extremities. Examination on admission confirmed that a growth had developed in the right breast. There was a slight paralysis of the facial nerves that caused an upward twitching to the right side of the mouth. Spasmodic constipation with a frequently impacted rectum was also a problem.

Temperature, pulse, and respirations, blood and urine analysis were all within normal limits and showed very little variation as time went on. Mrs. Andrews complained of severe pain along the back of her skull and down her spine. She had some epigastric distress—a burning sensation in her stomach—with nausea and vomiting of greenish fluid. There was intermittent confusion regarding her surroundings, the time of day, etc. Her vision was sometimes impaired, sometimes normal. She seemed to have difficulty in grasping or holding objects with her hands—an apparent loss of muscle coordination. On admission she was very irritable and impatient, short of breath, and complaining of pain in her right side.

A fairly extensive series of x-rays had been taken prior to Mrs. Andrews' admission to hospital. The findings revealed:

1. Widespread areas of osteolytic metastasis of the skull.
2. A pathological fracture in an osteolytic lesion of the right fifth rib posteriorly.
3. A questionable area of infiltration in the right pubic bone. Otherwise, there was nothing remarkable about the pelvis.
4. Hypertrophic spondylitis in the lower thoracic and lumbar areas of the spine.

The gallbladder was reported to be functioning normally following tests. A later x-ray revealed that the sixth dorsal vertebra was irregular in outline and considerably decalcified. These findings accounted for Mrs. Andrews' inability to sit up without props.

TREATMENT AND NURSING CARE

Though x-ray treatments were ordered, it was found that anything under K.V.200 was useless. These treatments were not continued. Drug therapy included the following medications:

Methyl Testosterone—1 ampoule daily.
Cal-Bis-Ma—drams 2, p.r.n.

Miss MacDonnell is a student nurse at Hotel Dieu Hospital, Cornwall, Ont.

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The bland *Cal-Bis-Ma* was given to Mrs. Andrews to act as a neutralizing agent for her epigastric distress. This medication was more or less successful in relieving the heartburn.

The laxative effect of the *mineral oil* was not sufficient to relieve the chronic constipation. Despite this medication, the rectum frequently became impacted. Then it would be cleared manually and an enema given.

At first the *morphia* was fairly effective in relieving the pain of which Mrs. Andrews complained. She usually required two injections during the day and one at night. As the condition progressed, the doctor ordered *Hyperduric morphine* which is more concentrated than morphia in powder form. A solution of the active principal of the drug, it comes in ampoules of gr.½ and is administered intramuscularly. It has a longer lasting effect.

Mrs. Andrews was on a regular diet but her appetite was very poor. She craved different and unusual foods—olives, special jellies, etc. So far as possible these demands were met. To supplement her diet, she usually drank one or two eggnogs, to which an ounce of brandy had been added, each day.

Nursing care was planned to meet and relieve the various symptoms of which she complained. Mrs. Andrews was very cooperative and was usually in remarkably good cheer despite

the evident severity of her pain. Routine care of the mouth and skin was given, supplemented by frequent alcohol rubs. Pillows were arranged under her right side to relieve pressure. She was more comfortable in a dorsal recumbent position so was usually placed that way with an electric heating pad at her back.

SUMMARY

Mrs. Andrews has not responded to any of the treatment that has been given. Due to the advanced stage of her illness, it does not appear probable that anything other than relief from pain can be done for her. Curiously enough, Mrs. Andrews has given no hint that she understood that hers was a terminal illness.

From the care I gave to this patient I learned how quickly the physical well-being deteriorates in carcinomatosis. I have a greater understanding of the intense, continuous pain these patients suffer. It increased my patience, sympathy and admiration for her.

Casualty Care in Mass Disaster

One of the most dramatic and effective displays ever staged to emphasize the importance of civil defence health services was presented to delegates attending the convention of the Canadian Nurses' Association. Blood-stained, shattered "casualties" were handled for more than an hour at a makeshift "first aid post" set up at l'Académie Commerciale and nurses, many of them members of religious orders, stood throughout the whole performance to see how they were treated.

The demonstration was staged by the Civil Defence Health Planning Group of the federal Department of National Health and Welfare, members of the group being assisted in playing leading roles by volunteers from among the nurses and by Quebec residents.

While local students from Quebec High School doubled as "casualties," those attending to the numerous cases which came to attention of the treatment post, under a make-believe atomic attack, are medical people engaged in training nurses throughout Canada in dealing with the effects of atomic, bacteriological and chemical warfare, as well as with the operation, generally, of disaster medical and health services.

For a lay audience, much of the action would have been harrowing in the extreme, as stretcher cases on the point of death and people suffering from horrible, almost total burns, were brought in. Quarters had been set up in a damaged schoolhouse, which the local civil defence medical officer quickly had put in shape as a temporary hospital.

Photo Moderne Enrg., Québec.

The Improvised Casualty Station

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However, the audience to which the skit was presented evidently found it far from boring or protracted since many of them stayed in the humid atmosphere of the crowded demonstration hall throughout both presentations.

How varied and terrible would be injuries inflicted by modern war weapons was clearly brought out, as was the fact that organization could cope with almost any situation or number of casualties. The nurses saw a perfect example of coordinated teamwork and, in addition, learned the latest methods of treating the various types of injuries inflicted on atom bomb victims.

Among those attending the display was Dr. K. C. Charron, chief of the federal Civil Defence Health Planning Group, who had flown to Quebec for the occasion. Staging the display were, among others Dr. G. E. Fryer, medical consultant, and Miss Evelyn Pepper, nursing consultant of the Civil Defence Health Planning Group; Miss Dorothy Percy, chief superintendent of nurses, Department of National Health and Welfare; Miss Mary Acland, nursing supervisor, St. John Ambulance Association; Miss Mildred Walker, Miss Jeanne Grenier, Miss Ruth Kennedy, and Miss Alma Fletcher, of the Federal Health Services; Miss J. Robert, Ottawa; Miss Henriette Matte, Quebec City; Miss Grace Cowieson, Ottawa; Miss Marion Woodside, nurse on the staff of the Ottawa Public School Board; and other volunteers. James Gibbard, chief of the federal Laboratory of Hygiene, Ottawa, was an interested spectator.

Much of the success of the presentation was due to the terrifyingly realistic work of Major Richard Bingham, senior instructor at the federal Civil Defence Technical Training School, with his assistant, Dave Chaplin, and to Miss Margaret MacLaren, of national headquarters of St. John Ambulance. They used such implements as grease paint, chalk, imitation skin, bandages, simulated human organs and blood to achieve the effects.

CYCLOPEDIC MEDICAL DICTIONARY

By Clarence W. Taber and 15 Associates. This dictionary contains more nursing procedures and nursing care than are found in any handbook of nursing. Valuable during examinations, constantly used after graduation. 1,500 pages, 273 illustrations, fifth edition, 1948. Plain, $5.00; thumb indexed, $5.25.

MANUAL OF CLINICAL LABORATORY METHODS

By Opal E. Hepler, Northwestern University. This widely-used textbook for laboratory technicians and medical students furnishes explicit directions for the different laboratory tests. 405 pages, 84 tables, 36 figures, fourth edition, (rearranged, revised and enlarged), 1951. $10.25.

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Book Reviews

Health Observation of School Children—A guide for helping teachers and others to observe and understand the school child in health and illness, by George M. Wheatley, M.D., M.P.H., and Grace T. Hallock. 491 pages. McGraw-Hill Co. of Canada Ltd., 253 Spadina Rd., Toronto 4. 1951. Price $6.45.

Reviewed by Jenny M. Weir, Director, School of Nursing, Queen's University, Kingston.

The Metropolitan Life Insurance Company has a filmstrip and booklet on teacher observations "What the Teacher Sees" (both excellent learning aids for student nurses as well as teachers). Conversations and correspondence with individuals and groups, using these aids, gave the impression that teachers and interested laymen need background information to help them understand what they see in observing children. This book was written to meet this need.

The book leaves a good impression. It is well bound, printed clearly on good paper, with illustrations in black and white and some excellent color plates. The choice of words is fresh; jargon is avoided. Provocative questions, ideas for further study, and selected references appear at the end of each chapter. An example of questions gives an idea of the up-to-date nature of the book. How would you help a youngster who (a) is painfully conscious of being much smaller or larger than others in class; (b) shows that he resents your authority?

The material fits well into the interest-centred curriculum, the teacher learning about children at the normal school or college level. However, this book would be very valuable for the student in public health nursing and for the student nurse during the basic course. The section on the nervous system presents in a very clear manner a topic which is often confusing to the undergraduate nurse. For example, the autonomic nervous system is called the Department of Internal Affairs. "The autonomic takes the government of our body out of our minds."

The presentation is done in such a way that the reader finds that she is looking at her own processes as well as those expected in a child. "The teacher who is really interested in making friends with her students, in

inspiring and guiding them as well as in imparting knowledge, is a patent stabilizing force in the lives of children."

Two cardinal facts are submitted in the book:

1. No child who has reached the age of reason can be kept healthy solely by what is planned and done for him. The teacher must be concerned with the cultivation of correct attitudes and practices.
2. No child can get rid of an already existing defect merely by practising rules.

The teacher must cooperate in getting help for the child with a defect and in helping him to live with a defect which cannot be corrected.

The teacher is given expert guidance in understanding these facts, and help in interpreting them to children and parents. There may be a better book in this field—your reviewer has not seen it. The happy blending of mental and physical health; the necessary emphasis on defects and abnormal conditions but the encouraging emphasis on the child following his own path of development; comparison with himself, not adversely, with others. My one criticism would be that, although the material is vital to the teacher, it may be dealt with in too full a manner to get the attention warranted.

The Story of the Growth of Nursing—as an Art, a Vocation, and a Profession, by Agnes E. Pavey, S.R.N. 498 pages. British Book Service (Canada) Ltd., 1068 Broadview Ave., Toronto 6. 3rd Ed. 1951. Price $4.25

Reviewed by Mary A. Durnin, Nursing Arts Instructor, General Hospital, Medicine Hat, Alta.

In reviewing the developments that have brought nursing to the point where it can be regarded as an art, a vocation and a profession, the author divides her material into three periods: (1) From the dawn of history to the fourth century A.D.; (2) from the beginning of Christianity to about 1850 A.D.; (3) the past hundred years.

The entire book is sub-divided into small sections that would be an asset in using this book as a reference text for either teacher or student.

A brief history of various branches of nursing—for example, public health nursing, industrial nursing, nursing in military branches—is given; also the historical background of

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● Candidates must be British subjects, under 40 years of age, except in the case of ex-service women who are given preference. Application Forms obtainable from all *Government Agencies, the Civil Service Commission, Weiler Bldg., Victoria,* or *636 Burrard St., Vancouver 1,* to be completed & returned to the

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Supt. of Nurses in respective Units or to Personnel Assistant, Division of T.B. Control, 2647 Willow St., Vancouver 9, B.C.

and some modern developments in nursing. It is written from a British point of view, including a survey of nursing in America.

Basic Psychiatry, by Edward A. Strecker. 473 pages. Random House of Canada Ltd., 1149 King St. W., Toronto 3. 1952. Price $4.75.

Reviewed by Alberta Hornibrook, Supt. of Nurses, Mental Hospital, Selkirk, Man.

Dr. Strecker states in the opening sentence: "There is an iron curtain between the general public and psychiatry." He has written this book to help remove the mystery which has surrounded the practice of psychiatry and to give his readers a better understanding of mental disease. He tells "the story of science's progress in the study and treatment of the mind at odds with itself and the world."

The book gives a comprehensive study of the whole field of psychiatry. This includes chapters on causation, classification, symptoms, mental disease, treatment, a design for childhood, and the psychiatry of war.

The subject of treatment is well covered and forms of therapy utilized by the psychiatrist are fully described. Nurses actually engaged in psychiatric nursing and others who wish information on treatment of the mentally ill will find this chapter of great interest.

The whole subject matter is stimulating and the book is understandable and easy to follow. Actual cases are used for illustration and a few diagrams help to clarify and emphasize.

I would recommend this book to all readers. It will be welcome as an addition to nursing school libraries and will be an excellent source of information for lectures in the field of psychiatry.

Sociology and Social Problems in Nursing, by Sister Mary Isidore Lennon, R.N. 385 pages. McAinsh & Co. Ltd., 1251 Yonge St., Toronto 5. 1951. Price $5.25.

Reviewed by Florence Quigley, Shute Institute for Clinical and Laboratory Medicine, London, Ont.

Sister Lennon, who has been director of St. John's Hospital School of Nursing, St. Louis, director of Social Service Department and supervisor of Nursing Education, St. Louis Province, brings all of her experience plus ten years of study and thought to this book.

Her central theme is that man brings many social groupings into being and he constantly

passes from one group to another. The nurse must recognize man as a member of a group, understand man's origin, nature, and destiny in order to restore patients to normal social and physical functioning.

In the preface the purpose is stated as being "to discuss the nature of sickness, not with scientific objectivity but from the viewpoint of the student in hospital schools of nursing, so that it will help in the integration of health and social aspects in nursing, which in turn will result in better service to the patient."

The book is divided into two main parts, made up of eight units composed of 26 chapters, with preface, foreword, appendix, and index. Illustrations, graphs, and tabulations are used as well as review questions, summary, and bibliography at the end of each chapter.

Part One of the book "defines the scope of sociology and its relation to social sciences, discusses the basic features of society, and aims to familiarize the student with sociological terms."

Part Two "deals with the nature, causes, and social control of disease arising from physical, cultural, and mental sources; critical analysis of the factors involved in problems related to sickness; and a description of the agencies available for the solution of these problems."

The book is well set up with clearly defined black-letter headings. The illustrations are interesting but add very little to the educational value.

What about the student nurse, for whom this text is written? Could she obtain the necessary guidance from the Role of the Nurse or would a better correlation with the sociological problems which are so definitely stated be needed? How is the nurse to solve these problems? Page 59 gives a clear-cut outline of the duties of the nurse. In most of her roles throughout the book she seems to stand alone or she just "familiarizes herself with the services rendered by other professional groups and agencies and uses them." How she is to use them is not too definite. There is no suggestion of teamwork between doctor, nurse, social service worker and agencies, for example, to decide what needs must be met in order to help the patient to assist himself in his own rehabilitation. Maybe "use" has a broader meaning than I am indicating.

It is questionable whether review questions

THE ASSOCIATION OF NURSES of the PROVINCE OF QUEBEC

The 1952 Fall Examinations for Provincial Registration will cover two groups of candidates and will be held as follows:

EXAMINATIONS FOR REGISTRATION —PART II:

Graduates desiring to qualify for a licence to practise will write on **November 17, 18 and 19, 1952.** Candidates will not be permitted to write these examinations until they have actually completed their training and hold the diploma of their school. *Applications must be received by October 15, 1952.*

EXAMINATIONS FOR REGISTRATION —PART I:

Students who will have completed their first year will enter the Examinations for Registration, Part I, which will be held on **October 20, 21, 22 and 23, 1952.** (Time to be announced in each school.) *Applications must be received by September 17, 1952.*

For application forms and all information relating to the examinations, apply to the headquarters of the Association.

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For further information write to:

Supt. of Nurses, General Hospital, Winnipeg, Man.

or work or study projects, which some of them are, at the end of the chapters have the highest educational value. Should not the nurse be stimulated by past experience and present need to seek her own solution and formulate her own questions and projects?

Links With Life, by S. R. Laycock, Ph.D. 60 pages. The Ryerson Press, 299 Queen St. W., Toronto 2B. 1951. Price 75 cents. *Reviewed by M. A. Rutherford, Regional Supervisor, Division of Public Health Nursing, Ontario Dept. of Health.*

Dr. Laycock has again written an excellent, short, easily read, educational book, which will be welcomed by public health nurses and doctors giving service to elementary and secondary school students.

It is a small book—only ten chapters. Each deals with different relationships within the family—e.g., The Girl and Her Dad, A Boy and His Mother, Boy Meets Girl, etc. Each gives two interesting case histories—one of the "discipline method" and the other "the newer approach of considering each member of the family as an individual, within the family."

At the end of each chapter there are "questions for discussion." These would stimulate active discussion in any group—e.g., Home and School Associations, Parent-Teachers Associations, etc.—who is interested in the adolescent.

This book should be in every public health library and used as a reference for staff education.

M.L.I.C. Nursing Service

Claire Bernier and *Madeleine De Santis* have returned to duty on the Montreal staff of the Metropolitan Life Insurance Company Nursing Service after completion of the public health nursing course at the University of Montreal. *Willa Ahern,* formerly in charge of the nursing service for employees at the International Nickel Co. at Sudbury, has resigned from the company's service. *Catharine Lamarre*'s resignation has also been accepted from the Montreal staff.

There are plenty of alternatives for healthy exercise besides strenuous sports and if you are one of the "over-forties" who is concerned about losing your youthful vigor, don't

overdo it in an attempt to show that there is "plenty of fight in the old gal yet." Like a machine, the human body decreases in reserve power with age and, unless we take care of it properly, it will wear out prematurely.

News Notes

ALBERTA

WAINWRIGHT

The Wainwright Chapter, which was formed in February, has been holding regular monthly meetings at the local hospital. Mrs. V. Perkins, the president, attended the course on Nursing Aspects of A.B.C. Warfare and all members have now received instruction in this vital aspect of Civil Defence. The nurses assisted the local Red Cross with the Blood Donors Clinic in May, L. Tweedie acting as convener. Mrs. A. Stanton was the chapter's representative to the A.A.R.N. annual meeting held at Banff in May.

BRITISH COLUMBIA

PRINCE GEORGE

Dr. J. G. McArthur was the guest speaker at a regular meeting of Fort George Chapter when he spoke to the nurses on "Diabetes." This was the first of a series of refresher courses in relation to the recent course in A.B.C. Warfare. M. McKinlay was chosen as delegate to the R.N.A.B.C. annual meeting in Victoria. The councillor from the Central Interior District was C. Bachelar of Smithers. Ten dollars was donated to the Arthritis Society. The annual nurses' church service was held in June. A nursing scholarship, worth $125, was presented, on behalf of the chapter, by Mrs. D. Boyle to R. Dalgleish, a graduate of the local high school.

M. Clare, a native of Prince George, and a recent graduate of St. Joseph's Hospital, Victoria, represented her class at the C.N.A. biennial convention in Quebec City.

E. Hassett, an honors graduate from the Royal Columbian Hospital, New Westminster, is now on duty with the Cariboo health unit, replacing Mrs. C. Stevens.

MANITOBA

WINNIPEG

Misericordia Hospital

The final meeting of the alumnae association was held at "Moores" when a chicken dinner was enjoyed by the members. An entertaining program was provided and the following officers were elected:

Honorary president, G. Thompson; president, M. Wilson; vice-president, Mrs. V. McCullough; secretary, Mrs. E. Laveque; treasurer, D. Borthistle. Committee conveners: Social, Mrs. E. Martin; visiting and membership, Mrs. E. Christianson; program,

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This course is especially valuable to those contemplating Public Health, Industrial, or Tuberculosis Nursing.

For further information apply to:

Director of Nursing,
Mountain Sanatorium,
Hamilton, Ontario.

Mrs. E. McLaren. The representative to *The Canadian Nurse* is B. Philippe.

NEW BRUNSWICK

Saint John

The N.B.A.R.N. sponsored a very successful seminar for supervisors and head nurses of New Brunswick and P.E.I. at the General Hospital. M. Jean Wilson and Ella Howard, assistant professors at the University of Toronto School of Nursing, conducted the course for the 50 nurses present. The topic was "The Role of the Head Nurse and Supervisor in Administration and Clinical Teaching."

The study of personnel policies formed the summer activity for Saint John Chapter as decided at the May meeting, held at St. Joseph's Hospital. F. Saunders, the president, was in the chair. M. Murdoch outlined plans for the N.B.A.R.N. annual meeting to be held in Saint John on September 24 and 25. M. McKean, of the teaching staff of the local high school, was guest speaker. She gave an account of her trip to England and Scotland in 1951 as one of the teachers who were guests of Lord Beaverbrook. Her talk was illustrated with colored lantern slides.

Srs. Rosarie and Helen Marie, assisted by members of the hospital teaching staff, served refreshments.

General Hospital

Prize winners of the 1952 class of the School of Nursing included: B. M. Greene (valedictorian), B. Zekite, V. M. McDougall, F. M. Kee, F. M. Bent.

Muriel MacKenzie is now on the staff of the V.O.N. K. Donahue has joined the Department of Health, Saint John. Mary MacKenzie is now on duty at S.J.G.H. while M. Stuart and E. Sherwood have resigned to go to British Columbia.

Mary E. MacDougall, medical missionary attached to Dondi Hospital, United Church of Canada mission at Angola, Portuguese West Africa, is a visitor to the city. A member of the class of 1943 and a native of Truro, N.S., Miss MacDougall attended several conferences in Canada and the U.S. this summer while on furlough for a year.

ONTARIO

District 1

London

Verna Berryhill, a graduate of Victoria Hospital, will undertake the services of a missionary-nurse in South America. Miss Berryhill has been commissioned for life as a missionary-nurse by the Fifth Avenue Presbyterian Church, New York, and has chosen Colombia or Chile so that she can work among Spanish-speaking people. Miss Berryhill has her certificate in public health nursing from the University of Western Ontario, winning the V.O.N. scholarship in London in 1945.

After serving for three years as nurse-in-charge of the V.O.N. at Collingwood, Miss Berryhill took a missionary-theological course for a year, then received her certificate in

nurse-midwifery at the Maternity Centre, New York. Before being assigned to her district in South America, Miss Berryhill must take courses in Spanish at San Jose, Costa Rica.

SARNIA

An eight-year term as director of nursing at the General Hospital concluded in June when a farewell party was held in honor of Mrs. Helen F. Griffiths, attended by members of the hospital staff, civic dignitaries, and friends.

Born near Minneapolis, Minn., Mrs. Griffiths came to Sarnia in 1944 after graduating from the Victoria Hospital School of Nursing, London, and serving at the Toronto Western Hospital. From 1947 to 1949 she was supply room supervisor. Over 40 nurses were trained at S.G.H. during the period when she was in charge. Many of them were among the 100 guests in attendance. She now resides in Leamington with her husband.

DISTRICT 2

Brantford General Hospital

Anna Stein, a B.G.H. graduate, is now a public health nurse in the Stratford area. Miss Stein served for seven years at the Red Bird Hospital, Beverly, Ky., as well as in the public health field in Kitchener. Prior to her nursing career, Miss Stein had experience teaching in the district.

DISTRICT 4

PORT COLBORNE

A meeting of Niagara Peninsula Chapter was held in June at Lakeside Park, following a basket picnic lunch. D. Sharpe, chairman, reported that first aid classes, sponsored by the Community Nursing Registry, St. Catharines, are planned for the fall. An auction sale was conducted by E. Secord, the proceeds serving to supplement the Overseas Parcels Fund. N. Hodgins was the winner of the draw for the petit point pictures.

ST. CATHARINES

General Hospital

A meeting of the Mack Training School Alumnae Association took the form of a picnic supper at the nurses' cottage in Port Dalhousie. B. Shepherd gave her report on the R.N.A.O. annual meeting.

DISTRICT 6

BELLEVILLE

A. Dorothy Potts, director of nursing at the General Hospital, has been named by WHO to organize a school of nursing at Dacca in East Pakistan. A nursing sister with the R.C.A.M.C. with four years' service overseas during World War II, she has been at Belleville since 1949.

DISTRICT 8

OTTAWA

Civic Hospital

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ing Alumnae Association was held in June at the Chateau Laurier when the class of 1952 were special guests. The classes of 1927, 1932, and 1942 held their respective anniversaries, members in attendance from Aklavik, Hollywood, B.C., and Nova Scotia. An amusing and interesting feature was a fashion parade, showing the changes in nurses' uniforms from 1920 to the present.

General Hospital

M. Gormley and P. Shane have accepted positions on the general staff of the Vancouver General Hospital. R. McIsaac, who completed the advanced course in public health nursing at the University of Toronto School of Nursing, is now a supervisor with one of the health clinics in Ottawa. H. McDonald, who attended U. of T. with Miss McIsaac, is supervisor of the health unit at Bracebridge, Ont.

District 9

North Bay

Dr. Tom Dixon, psychologist from Sudbury, was the guest speaker at the annual meeting of the district held in May. Due to the size of area of District 9, it was decided to separate and form two districts. The new District 9 includes: North Bay, Sudbury, Sault Ste. Marie, taking in the surrounding areas of Blind River, Manitoulin Island, Sturgeon Falls, and Mattawa. The newly formed District 12 comprises: Cobalt, Haileybury, New Liskeard, Englehart, Kirkland Lake, Matheson, Iroquois Falls, Timmins, Cochrane, Kapuskasing, Hearst, and Moosonee.

Edith Fenton, of the R.N.A.O. office, was present at the meeting to inaugurate the officers of the two new districts.

Miss Conrad and E. Wilson represented the student nurses of St. Joseph's Hospital at the R.N.A.O. annual meeting in Toronto. Of special interest to them was the panel discussion among the students, entitled "Citizenship and the Student."

PRINCE EDWARD ISLAND

A meeting of the two districts of the A.N.P.E.I. took the form of a picnic at Cavendish in July. Close to 50 members attended, coming from various parts of the Island. Sr. M. Stanislaus was in the chair. A motion was passed that an expression of appreciation from the A.N.P.E.I. be sent to Gertrude M. Hall, retiring general secretary of the C.N.A., for the outstanding contributions she has made to Canadian nursing and, in particular, for the help and encouragement she has given to the P.E.I. association.

Reports and reviews of the Structure Study and the Canadian Commission on Nursing, as presented at the C.N.A. biennial meeting in Quebec, were given. Considerable discussion followed a report on meetings of the Executive Committee with the Minister of Health and Welfare to discuss academic standards of education in P.E.I., nursing educational standards, and the shortage of nursing personnel in the province.

Due to her marriage and future residence in Ontario, Helen Arsenault has resigned from her many activities in the association. The president reported that an expression of appreciation had been sent to her for her active service in the association.

After the picnic supper, a few of the provincial committees were able to get together for meetings.

The association annual meeting is planned

for some time between September 15 and 22 in Charlottetown.

QUEBEC

MONTREAL

St. Mary's Hospital

Mary E. Des Rosiers, a native of Windsor, Ont., and a graduate of the School of Nursing of this hospital, has left for Calcutta, India, where she will take up duties as nursing arts instructor with WHO. Miss Des Rosiers served with the R.C.A.M.C. during World War II at the time of the invasion into Germany. Following duty in hospitals in Holland, she returned home in 1946 to enrol in the McGill School for Graduate Nurses, receiving her B.N. degree. Instructing in Montreal schools of nursing, she also was on the examining board of the A.N.P.Q.

SASKATCHEWAN

SASKATOON

City Hospital

The alumnae association entertained members of the 1952 graduating class at a theatre party followed by a reception when the best wishes of the alumnae were expressed by the president, B. Robinson. Each graduate was presented with a membership in the association. Mmes J. Tait and J. M. Yourk presided at the tea table, members of the social committee assisting.

Members of the supervisory and general staff arranged a Mother and Daughter Tea in honor of the 1952 class. Graduates and guests were received by Mrs. H. Armstrong, D. Bell, and M. Hill. Presiding over the teacups were Mmes N. Osiowy and A. Woods, assisted in serving by P. Sharp, L. Kangas, M. D. Russell, M. Maber, C. Casswell, E. Shepperd, B. Robinson, D. Bradley, J. Chellew, M. Melnik, A. Simes, E. Jefferson, E. Dueck, R. Ward, and Mmes H. McKenzie, M. Berry, and J. M. Yourk.

Sixty-six graduates received their diplomas and pins at the colorful exercises when Mayor J. S. Mills acted as chairman. The presentation of diplomas was made by Mr. L. T. Muirhead, hospital superintendent, and the nurses received their pins from Mrs. H. Armstrong, director of the school of nursing. Prize winners included: S. and J. Howes (twins), M. Enmark, V. Wright, J. McGratten, M. Evans, and D. Gibson. Dr. C. Biro, president of the medical staff, gave the graduation address. The valedictorian was E. Gillespie.

A reception, following the exercises, was held at *H.M.C.S. Unicorn* when hundreds of guests extended congratulations to the members of the class. Presiding over the tea table included: Mmes G. M. T. Hazen, J. S. Mills, L. H. McConnell, C. Biro, T. H. Bennie, W. S. Kinnear, H. D. Dalgleish, and Miss B. Robinson.

Saskatoon Sanatorium

The following have resigned from the staff: M. (Lee) Shier to go to Colonsay, Sask.; R. (Dulmage) Shewchuk to go to Prince Albert; Vera Lucke to go to Banff.

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Manitoba—Registered Nurse for 260-bed Sanatorium for Indians, operated by Sanatorium Board of Manitoba. Situated in progressive city of 20,000 pop., 140 miles west of Winnipeg. Good working conditions; straight hours; 44-hr. wk.; vacations with pay; 11 statutory holidays; attractive salary; retirement annuity & group insurance. Major surgical nursing. Good opportunity for advancement for anyone interested in tuberculosis training. For further information apply, stating qualifications, Supt. of Nurses, Brandon Sanatorium, Brandon, Man.

Registered Nurses for General Duty immediately for 80-bed Municipal Hospital, Grande Prairie, Alta. Salary: $175 per mo. with full maintenance & laundry provided. $5.00 per mo. bonus at end of each 6-mo. period. Fare from Edmonton refunded after 6 mos. service. 3 wks. vacation after 1 yr. & all statutory holidays. Straight 8-hr. duty. Comfortable nurses' home. Apply F. Gow, R.N., Nursing Supt.

Graduate Nurses (2) for General Duty for immediate future. Starting salary: $200 with annual increments of $5.00 per mo. Full maintenance $40. Statutory holidays paid. 28 days vacation after 1 yr. service. Usual sick leave. Apply Miss A. Naomi Pow, Supt. of Nurses, Slocan Community Hospital, New Denver, B.C.

General Staff Nurses for 600-bed University Hospital. Openings in all services. Personnel policies meet approved minimum standards of North Carolina State Nurses' Ass'n. Salary: $160 per mo. with complete maintenance ($220 without maintenance). $20 additional for permanent evenings & nights. $120 annual increment for satisfactory service. 44-hr. wk. 24 days vacation the 1st yr.; 30 days per yr. thereafter. Ill time allowance same as vacation. 6 holidays per yr. Exceptional opportunity for furthering education in Duke University. Write Director of Nursing Service, Duke University Hospital, Durham, North Carolina.

Registered Nurses for General Duty for new 30-bed hospital. Salary: $155 per mo. plus full maintenance. Located 20 miles south of Lethbridge. For further information apply Matron, Municipal Hospital, Magrath, Alta.

Public Health Nurses (qualified, experienced). Salary schedule: $2,200-2,900 depending on experience plus present Cost of Living Bonus, $202 per annum. Annual increment, $100. Pension plan. Car provided or car allowance. Apply Dr. C. W. MacCharles, Director, Northumberland-Durham Health Unit, Cobourg, Ont.

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Public Health Nurses for newly established Health Unit for work in generalized program. Salary by arrangement with Board. Provision for holiday & sick leaves & pension & hospitalization schemes are in operation. Cars supplied & maintained for nurses or they may be paid mileage for use of their own cars. Further information may be obtained from & applications should be sent to Sec.-Treas., Health Unit, Medicine Hat, Alta.

Public Health Nurses for newly established Minburn-Vermilion Health Unit for generalized public health program. Salary by negotiation with Board. Car supplied by Unit for use by nurse. Provision for holiday & sick leave & pension & hospitalization plans are in operation. Apply Sec.-Treas., Minburn-Vermilion Health Unit, Vermilion, Alta.

Public Health Nurses for program of generalized public health with newly established Vegreville Health Unit. Salary by arrangement with Board. Provision for holidays & sick leave & pension & hospitalization plans are in operation. Cars supplied by Unit for use by nurses or they may be paid mileage for use of their own cars. Further information may be obtained from & application should be sent to Sec.-Treas., Health Unit, Vegreville, Alta.

Asst. Supt. for Royal Alexandra Hospital, Edmonton, Alberta. For further information apply Supt. of Nurses.

General Duty Nurses. Vacancies in Pediatrics, Obstetrics, Medical & Surgical Nursing. Minimum gross salary: $195. Apply Supt. of Nurses, Royal Alexandra Hospital, Edmonton, Alta.

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Graduate Nurses for completely modern West Coast hospital. Salary: $210 per mo. less $40 for board, residence, laundry. $10 annual increments. Special bonus of $10 per mo. for night duty. 1 mo. vacation with full salary after 1 yr. service. 1½ days sick leave per mo. cumulative to 36 days. Transportation allowance not exceeding $60 refunded after 1st yr. Also **Evening Supervisor** from 4:00 till midnight. Salary commences at $225. Working conditions & perquisites same as nurses. Apply, stating experience, Miss E. L. Clement, Supt. of Nurses, General Hospital, Prince Rupert, B.C.

General Duty Nurses for 430-bed hospital. 44-hr. wk. 11 statutory holidays. Salary: $215-253. Credit for past experience. Annual increments. Cumulative sick leave. 28 days annual vacation. Apply Director of Nursing, Royal Columbian Hospital, New Westminster, B.C.

Nursing Arts Instructor & Asst. Supervisor for Operating Room for 450-bed General Hospital with 150 students Apply Director of Nursing, General Hospital, Saint John, N.B.

General Duty Nurses. Salary: $162.50 per mo. for new graduates. 2 meals, laundry. 8-hr. day, straight shift. $15 differential evenings; $10 nights. Vacation, sick time, statutory holidays, annual increments. Financial recognition for university, post-graduate work or years of experience. Also **Evening Nursery Supervisor & Labor Room Nurses**—experience in obstetrics, post-graduate study desirable. Salary depends on qualifications & past experience. Expenses for personal interview paid. Apply Supt. of Nurses, General Hospital, Winnipeg, Man.

Instructor of Nursing, Clinical-Obstetrical Supervisor & Operating Room Supervisor—all applicants must be qualified—for Victoria Public Hospital, Fredericton, N.B. Apply Director of Nursing.

Nursing Arts Instructor, Clinical Instructor, Dietitian & Staff Nurses. Apply Director of Nurses, Royal Inland Hospital, Kamloops, B.C.

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invites applications for **Administrative** and **Staff** positions in **Hospital, Public Health Nursing Services,** and **Blood Transfusion Service** for various parts of Canada.

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Asst. Night Supervisors (2)—capable of taking charge in Delivery Room. Gross salary: $210-265. 44-hr. wk. May live in residence. For full particulars apply Supt. of Nurses, General Hospital, Moose Jaw, Sask.

General Staff Nurses will find real opportunity to realize their ideals in our 337-bed Teaching Hospital with University affiliation. Community offers unlimited choice of cultural & recreational facilities. 40-hr. wk. 3 wks. vacation. Paid sick leave. Rotating shift $1.30-1.40 per hr. Differential of 10 cts. per hr. for evening & night shifts. Apply Director of Nurses, Evanston Hospital, 2650 Ridge Ave., Evanston, Illinois.

Registered Nurses, with Pediatric experience preferred, as **Head & Asst. Head Nurses** for Pediatric-Orthopedic Hospital. Apply Director, Shriners' Hospitals for Crippled Children, Montreal 25, Que.

Graduate Nurses for 175-bed Tuberculosis Sanatorium near Prince Rupert. Salary for General Duty, $232 per mo. plus yearly increases. Room, board, laundry at $30 per mo. Transportation refunded on promise of 1 yr. service. Apply airmail, giving full details of experience, Matron, Miller Bay Indian Hospital, Box 1248, Prince Rupert, B.C.

Public Health Nurses for Greater Montreal Branch of Victorian Order of Nurses. Interesting program of nursing care & health education to families & patient study groups. Stimulating staff education program. Salary: $2,400-3,000 with annual increments. Initial salary based on previous experience. 5-day wk. 4 wks. vacation. Apply District Supt., Victorian Order of Nurses, 1246 Bishop St., Montreal 25, Que.

General Duty Nurses for Medical & Surgical Depts. 44-hr. wk. 2 wks. sick allowance per yr. Hospitalization Plan. For further particulars apply Director of Nursing, General Hospital, Belleville, Ont.

General Duty Nurses. Basic monthly salary: $150 plus full maintenance. For well equipped 70-bed hospital with all-graduate staff. Apply Supt. of Nurses, Douglas Memorial Hospital, Fort Erie, Ont. (10 min. from downtown Buffalo).

General Duty Nurses for 680-bed General Hospital with School of Nursing. Beginning salary: $258; increase to $273 at end of 6 mos. employment. $15 increase 1 yr. after 1st increase. Differential of $10 for special services & p.m. & night duty. 40-hr. wk. 11 paid holidays. 3 wks. vacation. Free laundry. Cumulative sick leave. Temporary housing available. Apply Director of Nursing Service, General Hospital, Fresno, California.

General Staff Nurses for newly constructed hospital. Starting salary: $175 per mo. plus $10 differential for afternoon duty. Additional pay for post-graduate study & operating room technique & obstetrics. Good personnel policies. Apply Director of Nurses, General Hospital, Guelph, Ont.

NURSES WANTED

The **Indian Health Services** of the **Department of National Health & Welfare** require ***Registered Nurses & Licensed Practical Nurses*** for Hospital, fully modern Outpost Nursing Stations & Public Health Nursing positions.

Beginning Salaries — ***Registered Nurses,*** $2,300-2,720. ***Licensed Practical Nurses*** with 2 yrs. experience, $1,920-2,220. 44-hr. wk. 3 wks. leave with pay annually plus additional 12 days leave with pay in isolated areas. Educational opportunities.

Apply:

522 Dominion Public Bldg., Winnipeg, Manitoba (Telephone: 927-100).

Graduate Nurses—Attention! We're adding a few beds & will be needing a few nurses. Are you interested in working in a 50-bed active hospital close to Vancouver, B.C.? Salary & holidays according to R.N.A.B.C. recommendations. Apply Miss M. R. Ward, Langley Memorial Hospital, Langley Prairie, B.C.

Public Health Nurses (bilingual) for generalized program in County Health Unit. Halfway between Ottawa & Montreal. Car provided or mileage allowance on privately owned car. Minimum salary: $2,400. Apply Medical Officer of Health, Prescott & Russell Health Unit, Hawkesbury, Ont.

General Duty Staff Nurses for 515-bed General Hospital. Beginning salary: $230 per mo. with advancement to $250. $20 additional for evenings & nights. 40-hr. wk. Hospital & school of nursing fully approved. Apply Director of Nursing, The Grace Hospital, 4160 John R. St., Detroit 1, Michigan.

Registered Nurses for General Staff in 21-bed hospital. Salary: $155 per mo. Room, board & uniform laundry provided. Rotating shifts. 48-hr. wk. Blue Cross Plan. 3 wks. holiday after 1 yr. service. Apply Supt. of Nurses, General Hospital, Espanola, Ont.

Registered Nurses for General Duty Staff. Salary commences at £37-10-0 per mo. with full maintenance. Transportation allowance. For full particulars apply Matron, King Edward VII Memorial Hospital, Bermuda.

Registered Nurses for 100-bed hospital. 8-hr. day, 6-day wk. 1 week-end per mo. Rotating shifts. 3 wks. holiday per yr. Full maintenance. For full particulars apply Director of Nurses, St. Vincent de Paul Hospital, Brockville, Ont.

General Staff Nurses. Also **Science Instructor.** 125-bed General Hospital. 40 student nurses. 4 wks. vacation. Excellent salary. Apply, stating qualifications, Supt., Soldiers' Memorial Hospital, Orillia, Ont.

General Duty Nurses for Operating Room, Pediatrics & Surgical & Medical Nursing. For information & personnel policies apply Director of Nursing, Victoria Hospital, London, Ont.

General Duty Nurses. Salary: $173.23 (one hundred seventy-three dollars & twenty-three cents) monthly, paid on a bi-weekly basis; 26 pays in a yr. **Scrub Nurse.** Salary: $184.84 less $33 for perquisites. Salaries have scheduled rate of increase. 48-hr. wk. 8-hr. broken day: 3-11, 11-7, rotation. Cumulative sick leave. Pension Plan in force. Blue Cross. 3 wks. vacation after 1 yr. service. Apply Supt. of Nurses, Muskoka Hospital, Gravenhurst, Ont.

Registered Nurses for St. Joseph Hospital, Mt. Clemens, Michigan. 25 miles north of Detroit, near Selfridge Air Force Base. Optional 40- or 44-hr. wk. **Staff Nurses:** $12 day duty; $13 afternoon or night duty. State Standards. Apply Director of Nursing Service.

Registered Nurses (2) & **Matron** for hospital with 27 set up beds. Salaries: $160 & $200 per mo. plus full maintenance. 1 mo. holiday & usual sick leave. Hospital located in thriving town with good train & bus service. Apply Sec.-Mgr., Porcupine-Carragana Union Hospital, Porcupine Plain, Sask.

General Duty Nurses (2) for 36-bed hospital on C.P.R. main line & Trans-Canada highway. Salary: $155 & full maintenance with $5.00 increment every 6 mos. Sick leave with pay. 1 mo. holiday with pay plus statutory holidays each yr. 8-hr. day, 44-hr. wk. with rotating shifts. Apply Supt., Municipal Hospital, Brooks, Alta.

Graduate Floor Duty Nurses for Mount Hamilton Maternity Hospital, Hamilton, Ont. 44-hr. wk. Statutory holidays. Initial gross salary bi-weekly: $83 plus Cost of Living Bonus. For other perquisites & further information apply Supt.

General Duty Nurses for 500-bed Teaching Hospital with well planned rotation schedule. Salary: $210 per mo. gross plus annual increments for 4 yrs. B.C. registration required. Apply Director of Nursing, Royal Jubilee Hospital, Victoria, B.C.

Graduate Floor Duty Nurses for General Hospital, Hamilton, Ont. Gross initial bi-weekly salary: $83 plus Cost of Living Bonus of approx. $6.00 per wk. 44-hr. wk. For other perquisites & further information apply C. E. Brewster, Supt. of Nurses.

General Duty Registered Nurses for 35-bed hospital—one for Oct. 1, one for Nov. 1, 2 for Dec. 1. Salary to start: $160 per mo. & maintenance. Separate nurses' residence. At end of 1 yr. service 2 wks. holiday plus 2 wks. in lieu of statutory holidays. Also **Laboratory Technician**—one who is willing to learn & do X-Ray work. For further particulars apply Matron, Municipal Hospital, Vulcan, Alta.

Matron (fully qualified) for Union Hospital, Kindersley, Sask. Applicants preferred with at least 3 yrs. experience as matron. Fully modern, 40-bed hospital, built 2 yrs. ago. Very well equipped for general practice. New equipment. Staff of 11 R.N.'s with O.R. nurse; 4 doctors in practice. Town of Kindersley on main C.N.R. line Saskatoon to Calgary. Pop., 2,500. Very progressive town with facilities for entertainment. Apply, stating salary required, with copies of references, D. Fisher, Sec.-Mgr., Box 425, Kindersley, Sask.

Registered Nurses for General Duty for small General Hospital. Salary: **$140 per mo. with full maintenance.** 6-day wk. 8-hr. duty, rotating shifts. 3 increments of **$5.00 per mo. at 6-mo. intervals.** Blue Cross paid. 10 days sick leave per yr. 6 statutory holidays. 28 days holiday. Apply Lady Supt., Barrie Memorial Hospital, Ormstown, Que.

General Duty Nurses for 60-bed hospital. Salary: $150 per mo. with 3 annual increments of $5.00. 48-hr. wk. Straight 8-hr. duty. $5.00 extra for evening & night duties. Full maintenance. 4 wks. vacation at end of 1 yr. service plus 8 statutory holidays. Apply Alexandra Marine & General Hospital, Goderich, Ont.

Supt. of Nurses, Asst. Supt. of Nurses for 177-bed hospital. State salary expected. **Nursing Arts Instructor.** Salary: $220 gross. **Science Instructor.** Salary: $220 gross. **Head Nurse** for Private Wing—27 beds. Salary: $215 gross. **General Duty Nurses** for obstetrical, medical & surgical floors. Salary: $180-195 gross, depending on experience. 44-hr. wk. 2½ days holidays per mo. Half day on statutory holidays. 1½ days sick time per mo. cumulative to 30 days. Charge of $30 per mo. for board & room. Apply Mrs. M. Alexander, Acting Supt. of Nurses, General Hospital, Medicine Hat, Alta.

Asst. Director of Nursing Service. Full information on application. **Night Supervisor** (1). For 200-bed hospital in Niagara Peninsula. Gross salary: $255. **Registered Nurses** (2) with graduate experience in Operating Room. Gross salary: $215. 21 days vacation on completion of 1 yr. **Registered Nurses for General Duty.** Gross salary: Days—$210; afternoons—$220; nights—$215. 21 days vacation annually. 48-hr. wk., no broken shifts. 3 annual increments to all registered staff. Accommodation available in residence. Refund of train fare on completion of 12 mos. service. Sick leave—1½ days per mo., cumulative to 54 days. 9 statutory holidays. Apply Director of Nursing, County General Hospital, Welland, Ont.

Registered Nurses for 34-bed General Hospital. Salary $165 per mo. for 1st yr., $175 for following yrs.; $30 per mo. extra for night duty. Full maintenance. 3 wks. vacation with pay for 1st yr., 4 wks. after 2 yrs. service. 12 days sick leave a yr., cumulative to 30 days. All statutory holidays. Travel expenses paid within Province of Manitoba for personal interview. Apply Supt. of Nurses, Altona Hospital, Altona, Man.

Registered Nurses for responsible positions as **Charge Nurses** ($195-$200) & **Nursing Supervisors** ($205-$215) in major surgical wards at Manitoba Sanatorium, a 280-bed institution at Ninette, Man. Well furnished & comfortable rooms, newly decorated. Generous vacations with pay. 11 statutory holidays. Contributory pension plan & other benefits. Apply Sanatorium Board of Manitoba, 668 Bannatyne Ave., Winnipeg, Man.

Medical Records Librarian to take charge of dept. in 200-bed hospital, in Ontario. Write, giving summary of experience & training, c/o Box P, The Canadian Nurse, Ste. 522, 1538 Sherbrooke St. W., Montreal 25, Que.

Registered Nurses: General Duty (3) $260 per mo. **Operating Room Scrub Nurse** (2) $270 per mo. Annual increase of $10 per mo. 8-hr. day, 40-hr. wk. Paid vacation — 2 wks. after 1st yr., 3 wks. after 3 yrs., 1 mo. after 5 yrs.; sick leave cumulative to 30 days. Quarters in nurses' home available at $20 per mo. Train fare refunded after 1st yr. of employment. Hospital is 155-bed General Hospital located in Fresno, California, in the heart of San Joaquin Valley, convenient to San Francisco, Los Angeles, Pacific Ocean beaches & many national

parks. Several Canadian nurses are presently employed in this hospital as well as other hospitals in vicinity. Write for application form & visa information to C. H. Linville, Administrator, Community Hospital, 1234 "S" St., Fresno 1, California.

Graduate Nurses for General Staff Duty in 350-bed Tuberculosis Hospital. For further information apply Director of Nursing, Royal Edward Laurentian Hospital, Ste. Agathe des Monts, Que.

Operating Room Nurse (qualified). Salary according to qualifications. Also **General Duty Nurses.** Gross salary $175 for active 61-bed hospital in progressive Western Ontario town with population around 4,000—about 25 miles from London. Apply Supt., General Hospital, Strathroy, Ont.

Supt. of Nurses, preferably with degree or certificate in Nursing Administration or Teaching & Supervision, for new modern 120-bed hospital. Salary range: $300-$350 per mo. depending on qualifications & experience. There is no School of Nursing at present but the establishment of one is being considered. Apply Administrator, Union Hospital, Swift Current, Sask.

Registered Nurses (2) for General Duty for Killarney & District General Hospital. Gross salary: $190 per mo. 30-bed hospital all on one floor. Excellent living quarters. Summer resort town on Lake Killarney. Apply Matron, Miss E. Nixon or F. H. White, Sec., Killarney, Man.

Graduate Nurse for 40-bed Hospital who can take x-rays, do elementary laboratory work, look after O.R., caseroom & all sterile supplies. 5½-day wk., 8-hr. day. 1 mo. vacation with pay after 1 yr. 18 days sick leave per yr. Apply, stating experience, to Red Cross Hospital, Yellowknife, N.W.T.

Registered Nurse or good **Practical Nurse** for small Cottage Hospital in country district. Mostly maternity, with a few chronic cases. Apply North Queens Cottage Hospital, Inc., Caledonia, Queens Co., N.S.

Hospital Supt.—Registered Nurse with hospital administration experience for 50-bed hospital with Training School. Full maintenance, vacation with pay & sick leave. Apply Chairman, Board of Trustees, Carleton Memorial Hospital, Woodstock, N.B.

General Duty Nurses for Kootenay Lake General Hospital, Nelson, B.C. R.N.A.B.C. recommendations in effect. Excellent recreational facilities available. Single-room accommodation available in adjacent nurses' residence. Apply Director of Nursing.

Public Health Nurse for generalized program in Belleville. Salary: $2,200-2,500 with annual increase of $100. Allowance for experience. Employee benefits include Blue Cross, pension plan, sick leave & 4 wks. annual vacation. Apply, Sec., Board of Health, Belleville, Ont.

Graduate Nurses for General Duty. 48-hr. wk., 7 statutory holidays, 3 wks. vacation after 1 yr. service, 2 wks. sick leave per yr. Excellent train & bus service to Ottawa. Apply Supt., Arnprior & District Memorial Hospital, Arnprior, Ont.

General Duty Nurses immediately for Trail-Tadanac Hospital, Trail, B.C. Personnel practices as outlined by Reg. Nurses' Ass'n. of B.C. Apply Director of Nursing.

Registered Nurses for Municipal Hospital, Drumheller, Alta. **General Duty Nurses** receive $165 per mo., plus full maintenance. $5.00 extra for post-graduate training & odd shifts; $10 extra for ward supervising. Apply Supt. of Nurses.

Registered General Duty Nurses immediately for active 31-bed hospital. Comfortable living accommodation. Good salary plus full maintenance. 3 wks. vacation after 1 yr. service. Apply Supt., Little Long Lac Hospital, Geraldton, Ont.

Day Supervisor capable of assuming responsibility as **Asst. Supt.,** Also **4-12 Supervisor** for 50-bed General Hospital in town on Lake Ontario, close to Toronto. Apply, giving full particulars as to age, qualifications, experience & references, Supt., General Hospital, Cobourg, Ont.

Matron for The Wales Home for Protestant Aged at Richmond, Que. (90 beds). Extension now under construction will increase capacity to 160 beds. Salary: $2,400 per annum plus full maintenance. Apply, stating qualifications & experience, Sec., The Wales Home, Richmond, Que.

Associate Chief Medical Record Librarian (*new position*); **Sr. Medical Record Librarrian; Medical Record Librarian** (new position) for 1,500-bed West Coast teaching hospital with newly organized Medical Records Dept. & staff of 36. All applicants must be registered. Apply c/o Box T, The Canadian Nurse, Ste. 522, 1538 Sherbrooke St. W., Montreal 25, Que.

Supt. of Nurses for 22-bed well equipped hospital. Staff consists of 4 Registered Nurses, 4 ward aides, lab. & x-ray technician, housekeeper, cook, cook's asst. & janitor. Straight 8-hr. shift. Separate modern nurses' residence. No business matters to handle. Apply, stating salary expected, Sec.-Mgr., Union Hospital, Hafford, Sask. (Write or phone & reverse charges).

Supervisor for New Obstetrical Wing. Post-graduate experience essential. Salary: $200 per mo. with maintenance. Apply Supt., Soldiers' Memorial Hospital, Orillia, Ont.

Operating Room Supervisor (special preparation preferred). Also **Dietitian & Night Supervisor** for 100-bed hospital. Salary depends on qualifications & experience. Apply Soldiers' Memorial Hospital, Campbellton, N.B.

General Duty Nurses immediately for 40-bed hospital. Salary open. Travelling expenses refunded after 6 mos. service. Rotating 8-hr. shifts. 6-day wk. 1 mo. vacation with pay after 1 yr. Apply Supt., Lady Minto Hospital, Chapleau, Ont.

General Duty Nurses for Tuberculosis Chest Surgical Unit. Previous experience desirable but not essential. 8½-hr. day, 5½-day wk. Initial salary according to experience—minimum $165 plus meals; $10 per mo. extra for night duty. 1 mo. annual vacation & 8 days statutory holidays. Apply Director, Nursing Services, Royal Edward Laurentian Hospital, 3674 St. Urbain St., Montreal 18, Que.

Registered Nurses (2) for 74-bed General Hospital. 44-hr. wk., rotated shifts. 1 mo. vacation. Gross salary: $177.50 plus laundering of uniforms. $5.00 increases after 3 mos., 9 mos. & 21 mos. later. Residence accommodation available at $15 per mo. Meals available at hospital—30c. per meal. Apply Supt. of Nurses, General Hospital, Portage la Prairie, Man.

Registered Nurses for new 20-bed hospital. Salary: $140 plus maintenance. 1 mo. holiday per yr. For further particulars apply Matron, Gatineau Memorial Hospital, Wakefield, Que.

Supt. for Arnprior & District Memorial Hospital, Arnprior, Ont. Apply, stating experience, qualifications, at least 2 references, salary expected & when available, to J. P. Mulvihill, Chairman of Management Committee, Box 432, Arnprior, Ont.

Matron (1) & **Nurse** (1) for Union Hospital, Lucky Lake, Sask. Salaries: $200 & $175 plus maintenance, respectively. Apply G. D. Clark, Sec.-Treas., Lucky Lake, Sask.

Victorian Order of Nurses

The following are staff changes in the Victorian Order of Nurses for Canada:

Appointments—Brampton, Ont.: *Marion Pope* (Toronto Western Hosp. and University of Toronto) as nurse in charge. Bridgewater, N.S.: *Irene Andrews* (Ottawa Civic Hosp. and Dalhousie University) as nurse in charge. Burnaby, B.C.: *Audrey Hunter* (Vancouver Gen. Hosp. and University of British Columbia). Calgary: *Mary Ann Hoggarth* and *Loraine M. Marshall* (Holy Cross Hosp., Calgary). Cobalt, Ont.: *June Woodruff* (Montreal Gen. Hosp. and McGill University) as nurse in charge. Collingwood, Ont.: *Mary Henderson* (St. Joseph's Hosp., London, and U. of T.) as nurse in charge. Cornwall, Ont.: *Mrs. Betty Kilgour* (Royal Victoria Hosp., Montreal, and McGill U.). Gananoque, Ont.: *Mary Geiger* (Hamilton Gen. Hosp. and University of Western Ontario) as nurse in charge. Kentville, N.S.: *Jean Forrest* (Toronto Gen. Hosp. and McGill U.) as nurse in charge. Kirkland Lake, Ont.: *Isobel Simister* (O.C.H. and U. of T.) as nurse in charge. Liverpool, N.S.: *Allison Cleland* (M.G.H. and McGill U.) as nurse in charge. London: *Margaret Wilson* (Victoria Hosp., London, and U.W.O.)

Moose Jaw, Sask.: *Donna Baldwin* (Grace Hosp., Winnipeg, and University of Manitoba) as nurse in charge. North Vancouver: *Mrs. Muriel Robinson* (R.V.H., Montreal). Ottawa: *Thelma Pritchard* (O.C.H. and McGill U.). Pictou, N.S.: *Jean McLaren* (R.V.H., Montreal, and McGill U.) as nurse in charge. Rouyn-Noranda, Que.: *Rosalie Proulx* (Hotel Dieu, Sherbrooke, and University of Montreal). Ste. Anne de Bellevue, Que.: *Marcelle Jutras* (Hôp. Gén. de la Miséricorde, Montreal, and U. of M.). Sarnia, Ont.: *Gladys Alexander* (Hamilton Gen. Hosp. and Queen's University). Smiths Falls, Ont.: *Marjorie Rideout* (R.V.H., Montreal, and McGill U.) as nurse in charge. Surrey, B.C.: *Clara Gould* (V.G.H. and U.B.C.). Vancouver: *Mrs. Grace Allan*

(Women's College Hosp., Toronto). West Vancouver: *Elizabeth A. Robertson* (V.G.H.). Whitby, Ont.: *Margaret Greig* (H.G.H. and U. of T.) as nurse in charge. Winnipeg: *Gladys Spiers* (St. Boniface Hosp., Man., and U. of Man.). York Township, Ont.: *Lilian Coates* (Royal Albert Edward Infirmary, Lanc., Eng.).

Resignations—Calgary: *Roberta Nixon, Marguerite Rose.* Cobalt: *Grace Latham.* London: *Margaret Lucas.* Medicine Hat: *Beulah Rose.* Niagara Falls: *Ruth Walker.* Ottawa: *Mrs. E. Boyd.* Rouyn-Noranda: *Stella Warwick* as nurse in charge. Sydney, N.S.: *Mary Harrington.* Toronto: *Norah Sullivan.* Whitby: *Helen Hobbs* as nurse in charge.

Differences in Survival

Quite generally, the countries with the best mortality records at the childhood ages also show the most favorable experience in the period from adolescence to middle life and to old age.

The probability of surviving the hazards of infancy and childhood are better in the United States than almost anywhere else in the world. According to the 1949 life table for white persons, 955 out of every 1,000 boys and 965 of every 1,000 girls can expect to reach age 15. Only New Zealand has a better record but its advantage is practically negligible. Other countries that rank high with respect to the survivorship of children are Australia, The Netherlands, England and Wales, and Sweden.

In sharp contrast to the favorable experience in Western Europe and in the English-speaking countries elsewhere is the record for the lesser developed areas of the world. In Mexico, as recently as 1940, only two-thirds of the newborn could expect to celebrate their 15th birthday. A similar situation prevailed in a number of Central and South American countries, including Chile and Guatemala. On the other side of the globe, Ceylon fared little better, with only about three-fourths of the newborn of each sex surviving to age 15. Unfortunately, data are lacking for the large majority of Asiatic countries, including India and China, where the infant and child mortality is probably appalling, measured by western standards.

— *M.L.I.C. Statistical Bulletin*

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Alberta Association of Registered Nurses

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NEW BRUNSWICK

New Brunswick Association of Registered Nurses

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QUEBEC

The Association of Nurses of the Province of Quebec

The Association of Nurses of the Province of Quebec, created by Licensing Act, April 17, 1946, replacing The Registered Nurses Association of the Province of Quebec, Incorporated February 14, 1920.

Pres., Mlle A. Martineau, 671 ave Ogilvy, Montréal 15; Vice-Pres. (*Eng.*), Sr. M. Felicitas, Miss H. Lamont; (*Fr.*), Sr. St. Ferdinand, Mlle G. Charbonneau; Hon. Sec., Miss M. Wheeler; Hon. Treas., Mlle E. Merleau; *Councillors*, Mlles M. Bissonnet (*Dist. 4*), A. Mailloux (*7*), M. A. Trudel (*8*), J. Gagnon (*9*), Mme M. Boisvert (*6*). The above constitute the *Executive Council* and are *Members of the Committee of Management*, together with: Mlles C. Julien, C. Samson, F. St. Pierre, L. Couet, M. Olivier, Misses V. Graham, K. Brady, C. Aitkenhead, Srs. Marie-Paul, Ste. Louise de Marillac, Marcil, J. Forest. *Advisory Com.*, Misses G. M. Hall, M. S. Mathewson, E. C. Flanagan, C. V. Barrett, Mlles R. Aubin, G. Lamarre, M. Lacombe, F. Verret, Sr. Valérie de la Sagesse, Mrs. J. Green. *Com. Chairmen: Institutional Nursing* (*Eng.*), Miss R. Francis, Western Div., Gen. Hosp., Montreal 25; (*Fr.*), Sr. Denise Lefebvre, Institut Marguerite d'Youville, Mtl 25; *Public Health* (*Eng.*), Miss A. Gage, 894 Osborne Ave., Verdun, Mtl 19; (*Fr.*), Mlle E. Merleau, Can. Red Cross, 3416 rue McTavish, Mtl 2; *Private Nursing* (*Eng.*), Miss R. Wood, 689 Rielle Ave., Verdun, Mtl 19; (*Fr.*), To be appointed. *Chairmen, Board of Examiners:* (*Eng.*), Miss A. Haggart, Royal Victoria Hosp., Mtl 2; (*Fr.*), Mlle J. Trudel, Hôp. Ste. Justine, Mtl 10. **Sec.-Registrar, Miss Winonah Lindsay. Visitor to French Schools of Nursing, Mlle Suzanne Giroux.** ***Association Headquarters, Suite 504-6, 1538 Sherbrooke St. W., Montreal 25.***

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SASKATCHEWAN

Saskatchewan Registered Nurses' Association (Incorporated 1917)

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A.A., Misericordia Hospital, Edmonton

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A.A., Vegreville General Hospital

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A.A., Vancouver General Hospital

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NEW BRUNSWICK

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A.A., Victoria General Hospital, Halifax

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A.A., Aberdeen Hospital, New Glasgow

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A.A., City Hospital, Sydney

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A.A., Brantford General Hospital

Hon. Pres., Miss J. M. Wilson; Pres., Mrs. G. Brittain; Vice-Pres., Miss A. M. Riddle, Mrs. V. Cheyne; Sec., Miss J. Spicer; Treas., Miss M. Gillin; *Committees: Gift*, Misses M. Southward, J. Greenaway; *Flower*, Mrs. J. Hurley, Miss D. Rashleigh; *Social*, Miss O. Plumstead; *Reps.* to: *Local Council of Women*, Mrs. E. Scott; *Council of Social Agencies*, Miss G. Westbrook; *Press & The Cdn. Nurse*, Miss M. Edward.

A.A., Brockville General Hospital

Hon. Pres., Misses Shannette, A. E. Moffatt; Pres., Miss H. Corbett; Vice-Pres., Mrs. H. W. Greene, Miss R. Carbery; Sec., Mrs. H. Bishop, 89 King St. W.; Treas., Mrs. W. Stewart; Asst. Sec.-Treas., Miss E. Thorpe; *Committees: Membership*, Misses V. Preston, J. Martin; *Visiting & Gift*, Miss V. Kendrick; *Social*, Mrs. D. Drummond; *Property*, Mmes H. W. Greene, W. E. Cooke; *Reps.* to: *Blue Cross*, Mrs. C. Babcock; *Press*, Miss Carbery.

A.A., Ontario Hospital, Brockville

Pres., Mrs. E. Wilkins; Vice-Pres., Mrs. O. Belfoi, Miss G. Best; Sec., Mrs. B. Kirker; Treas., Mrs. O. Bigford, 9 Hubble St.; *Committees: Membership*, Mmes J. Gaffney, C. Jenkins, M. Fairbourne; *Welfare*, Mmes S. Wilson, A. Haggerty, H. Forbes; *Social*, Mrs. R. Warner, Misses M. Martin, T. Lynch; *Rep.* to *Press*, Mrs. A. Dodds.

A.A., Public General Hospital, Chatham

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A.A., St. Joseph's Hospital, Chatham

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A.A., Cornwall General Hospital

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A.A., Hotel Dieu Hospital, Cornwall

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A.A., McKellar Hospital, Fort William

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A.A., Galt Hospital

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A.A., Guelph General Hospital

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A.A., St. Joseph's Hospital, Guelph

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A.A., Hamilton General Hospital

Hon. Pres., Miss C. E. Brewster; Pres., Miss G. Blyth; Vice-Pres., Mrs. E. Lamb, Miss N. Roncioli; Rec. Sec., Miss R. Bowslaugh; Asst. Rec. Sec., Miss M. Cameron; Corr. Sec., Miss M. Irving; Treas., Mrs. A. Massie, 56 Connaught S.; Asst. Treas., Miss V. Snyder; *Mutual Benefit Ass'n*—Sec.-Treas. & Asst.: Misses M. Morrow, A. Lush; *Committees: Exec.*, Misses E. Ferguson (conv.), M. Henderson, H. Smith, E. Bingeman, E. Kerr; *Program*, Misses A. Welstead (conv.), M. Macdonald; *Flower & Visiting*, Misses Kinsman (conv.), Fedorenko; *Membership*, Misses M. Stewart (conv.), V. Pezzetta; *Publication*, Misses J. Irwin (conv.), M. Knighton; *Budget*, Misses N. Coles (conv.), V. Snyder, Mrs. A. Massie; *Reps.* to: *Local Council of Women*, Mrs. J. Bristow; *R.N.A.O.*, Miss Suckling; *Women's Auxiliary*, Mrs. Daw; *Trustees, W. F. Langrill Educational Fund*, Misses M. Watson, H. Alderson, G. Hall, J. Harrison.

A.A., Ontario Hospital, Hamilton

Pres., Miss M. A. Seeman; Vice-Pres., Miss S. Legris; Sec., Miss E. Orr, O.H.; Treas., Miss L. Angle; *Committees: Social*, Misses A. Legree, A. Porteous, M. Abrams, Mrs. M. Stoneman; *Visiting*, Mmes M. Sutherland, D. Jeffrey; *Rep.* to *Press*, Mrs. A. Kroeker.

A.A., St. Joseph's Hospital, Hamilton

Hon. Pres., Sr. M. Geraldine; Hon. Vice-Pres., Sr. M. Ursula; Pres., Mrs. Bert Markle; Vice-Pres., Miss E. Quinn, Mrs. J. Tilden; Sec., Miss B. Clohecy, 61 E. Ave. S.; Treas., Miss N. Hinks; *Committees: Executive*, Misses A. McCowell, N. Walsh, M. Reding, Mrs. R. C. Wheatley; *Social*, Miss A. Payne; *Publicity*, Miss D. Rilett; *Reps.* to: *R.N.A.O.*, Miss E. Freeman; *The Canadian Nurse*, Miss A. McNamara.

A.A., Kingston General Hospital

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A.A., Kitchener-Waterloo Hospital, Kitchener

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A.A., St. Mary's Hospital, Kitchener

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A.A., Ross Memorial Hospital, Lindsay

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A.A., Ontario Hospital, London

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A.A., St. Joseph's Hospital, London

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A.A., Victoria Hospital, London

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A.A., Greater Niagara Hospital, Niagara Falls

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A.A., Oshawa General Hospital

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A.A., Lady Stanley Institute (Incorporated 1918) Ottawa

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A.A., Ottawa Civic Hospital

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A.A., Ottawa General Hospital

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A.A., St. Luke's Hospital, Ottawa

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A.A., Owen Sound General and Marine Hospital

Hon. Pres., Misses E. Webster, W. Cooke; Pres., Mrs. A. Story; Vice-Pres., Mrs. J. Dewar; Sec., Mrs. M. Keeling, 1064–1st Ave. A.W.; Treas., Miss E. Cook, 110–10th St. W.; *Committee Conveners: Program*, Miss M. Ankcorn; *Finance & Buying*, Miss A. Cook; *Social*, Miss E. McRae; *Reps.* to: *R.N.A.O.*, Mrs. G. Gillespie; *Blue Cross*, Miss R. Showell; *The Canadian Nurse*, Miss L. Schwartz.

A.A., Lorrain School of Nursing
Pembroke General Hospital

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A.A., Peterborough Civic Hospital

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A.A., St. Joseph's General Hospital, Port Arthur

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A.A., St. Thomas Memorial Hospital

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A.A., Sarnia General Hospital

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A.A., Stratford General Hospital

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A.A., Riverdale Hospital, Toronto

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A.A., St. John's Hospital, Toronto

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A.A., St. Joseph's Hospital, Toronto

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A.A., St. Michael's Hospital, Toronto

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A.A., School of Nursing, University of Toronto

Hon. Pres., Miss E. K. Russell; Hon. Vice-Pres., Miss F. H. M. Emory; Past Pres., Miss E. Dick; Pres., Miss Eileen Cryderman; First Vice-Pres., Miss Gwladwen Jones; Sec. Vice-Pres., Miss Phyllis Jones; Sec.-Treas., Mrs. Charles Querrie, 23 Marmaduke St., Toronto 3.

A.A., Toronto General Hospital

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A.A., Training School for Nurses of the Toronto East General Hospital with which is incorporated the Toronto Orthopedic Hospital

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Committees: Visiting, Miss MacLean; *Program*, Miss Trussler; *Social*, Miss Herbert; *News*, Misses G. Woodrow, J. Kennedy; *Reps.* to: *R.N.A.O.*, Miss R. Hollingsworth; *Blue Cross*, Mrs. R. Grice; *Registry*, Mrs. Proctor, Misses E. Roy, M. Stevenson; *Year Book & Class Rep.*, Mrs. R. Hunter.

A.A., Toronto Western Hospital

Hon. Pres., Miss B. L. Ellis, Mrs. C. J. Currie; Pres., Miss B. Miles; Vice-Pres., Misses K. Ellis, A. Bell; Corr. Sec., Miss M. McKenzie; Treas., Miss L. Burgess; *Blue Cross* Treas., Miss D. Armstrong; *Reps.* to: *R.N.A.O.*, Miss E. Smith; *The Cdn. Nurse*, Miss M. Steed.

A.A., Wellesley Hospital, Toronto

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A.A., Women's College Hospital, Toronto

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A.A., Ontario Hospital, New Toronto

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